Maternal and Child Health Services
Title V Block Grant

State Narrative for Connecticut

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The assurances and certifications are on file at the Connecticut Department of Public Health and are available from:

Director, Office of Affirmative Action
Connecticut Department of Public Health
410 Capitol Avenue
P.O. Box 340308
Hartford, CT 06134

An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The DPH Family Advocate recruited three families to read the MCHBG application, two meetings were held with the family readers. Working in conjunction with the Family Support Network, families were identified from geographically and socio-economically diverse areas to represent the populations served by the Maternal and Child Health Services Block Grant. All of the families received MCH services over the last year. An overview of the MCH programs and the MCHBG application process was presented at the first meeting. The role/input of readers was discussed and families were given the 2010 application to read. During the second meeting, information was gathered and questions answered. Family readers received a stipend for their participation.

The 2011 MCH application will be shared with the public by posting the application on the DPH web site and will be shared with advisory group committees. Input into Title V activities is encouraged throughout the year through involvement of individuals and families in various advisory groups and task forces. The Allocation Plan for the 2011 application will be shared through a Public Hearing at the Connecticut Legislature. Public Hearings are televised and archived and made available through the Connecticut General Assembly web site.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

C. ANNUAL NEEDS ASSESSMENT SUMMARY

This five-year Needs Assessment identified nine State Priorities that were very similar to those identified in the last needs assessment completed in 2005. Similarities included needs to: (1) Enhance data systems that support public health assurance, assessment and evaluation activities; (2) Address the continued obesity epidemic; (3) Reduce racial and ethnic health disparities relative to the MCH population's health status; (4) Enhance CYSHCN medical home initiative by focusing on the early identification of developmental delays, including autism; (5) Improve the health status of women with a specific focus on a mother's health and its potential exponential effect on her family; and (6) Improve access to health care programs and services.

While this year's State Priorities were similar, there are concrete differences in the specific focus of each state priority. These differences are demonstrated in the exact wording of each State Priority and the resulting State Performance Measure developed to measure the success of the activities to address the need.

The main change from the previous needs assessment were the addition of three State Priorities: (1) Improve mental/behavioral health services; (2) Enhance oral health services; and (3) Integration of the Life Course Theory. In the last needs assessment, both mental health and oral health were among the possible state priorities but were not selected either because other needs were identified as a higher priority (oral health) or the complexity of addressing the need was prohibitive (mental health). The addition of the Life Course Theory resulted from national and regional initiatives that raised this need to a high level of priority.

The changes in the MCH programs and system capacity has been moderately significant since the last five-year needs assessment.

Children and Youth with Special Health Care Needs
A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based systems and transition to all aspects of adult life.

The DPH Medical Home Advisory Council (MHAC), comprised of more than 40 representatives, including youth representation from CT Kids as Self Advocates (CT-KASA), from state and private agencies, community-based organizations and parents of CYSHCN, has a stronger role in providing guidance to DPH in its efforts to improve the system of care for CYSHCN by ensuring their connection to a medical home.

DPH is working to migrate the existing CYSHCN database to a web-based platform. This will allow for integration of data with other databases at DPH, and allow for future connection to Electronic Medical Records (EMR). The system will allow information from families; medical home based care coordinators, and other stakeholders to be integrated in support of CYSHCN program surveillance, planning and evaluation.

Pregnant Women, Mothers and Infants
Case Management for Pregnant Women is offered in 3 towns to provide comprehensive, integrated case management services during the perinatal and interconceptual periods to pregnant and post partum teenagers and women and their partners in an effort to improve birth outcomes.

Efforts to address racial and ethnic health disparities as they relate to low birth weight infants were started including the development of the Centering Pregnancy model of group prenatal care in organizations that provide outpatient prenatal care services to low income women, who are most at risk for delivering low birth weight infants.

The recession in CT has resulted in increased utilization of CHC. DPH supports thirteen health care corporations to provide preventive and primary health care services through Community Health Centers. Services provided in the CHC include the following essential elements of comprehensive health care: prevention, primary care, acute care, episodic care, care management of chronic health conditions of children and adults; behavioral health care; and dental/oral health care. As safety net providers, CHC are strategically located in areas of need and help address the issues related to access to care.

Children and Adolescents, Age 1 through 22 years.
The increase in the number of SBHC clinic sites and Expanded School Health programs sites has increased the provision of: outreach, physical exams, risk assessments, anticipatory guidance, diagnosis and treatment of acute injuries and illnesses, immunizations, chronic disease monitoring and management, health promotion/education/risk reduction activities, prescribing and dispensing medications, reproductive health care, laboratory testing, crisis intervention, individual, family, and group counseling, case management, referral and follow-up for specialty care, and linkages to medical homes and community based resources.

The key findings from the Internal DPH Workgroups, focus groups and surveys were shared with the Stakeholders' Committee. The Stakeholders' Committee considered the data presented and then selected the nine state priority needs areas to improve maternal and child health for the three target populations.

The DPH developed state performance measures to correspond to the priorities selected by the Stakeholders' Committee.

III. State Overview

A. Overview

Connecticut (CT) is a small state of about 5,000 square miles and 169 towns, and has an estimated statewide population of 3,501,252 (July 1, 2008). The average town population is about 20,000. Five towns have a population greater than 100,000: these are the towns of Bridgeport (136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037). In 2008, there were 41 towns that had high unemployment rates, of which18 had populations that exceeded the average. The need for social services in the state is not limited to towns of high population.

CT is characterized by high social and economic contrast and racial and ethnic diversity. It is the third smallest state in the U.S. in terms of area, but it has the 29th highest population and is the fourth most densely populated state. Approximately 88% of CT's population lives in urban areas. While CT is one of the wealthiest states in the country, several cities have high rates of poverty. With a median household income of $68,595, CT was ranked third highest in the nation in 2008.

Racial and ethnic disparities exist across town lines, and between urban and rural populations. Racial and ethnic diversity is increasing in CT. From 2000-2007, the state's Asian population increased by 38.2%, the native Hawaiian or other Pacific-Islander population increased by 29.3%, and the Hispanic/Latino population increased by 24.8%. Hispanics or Latinos have shown the most growth of any CT racial or ethnic subgroup in terms of overall numbers during this period. (The CT Health Disparities Report, 2009). In 2007, the Hispanic or Latino population comprised 11.5% of the CT population, black or African Americans 9.3% and Asian 3.4%. These differences have engendered the concept of two CT's -- one comprising people who live in the wealthiest state in the nation, and the other consisting of those who live in some of the most severe and concentrated pockets of poverty in the U.S. The overall health of CT's people varies between its wealthiest and poorest communities.

According to the U.S. Census Bureau (2006), one in ten (10.3 percent) CT children under 18 (84,000) lived in a household with income below the federal poverty level ($20,516 for a family of four). That's down from the 2004 level (12.4 percent) but represents no improvement from the 2003 level (10.1 percent), according to the U.S. Census Bureau's Current Population Survey (CPS). One in four (25.8 percent) CT children lived in a household with income below 200 percent of the federal poverty level in 2006, according to CPS data (The 2004 level was 23.9%). According to a second measure that uses a larger sample, 10.7 percent of CT children under 18 (86,000 children) in 2006 lived in a family with income below the federal poverty level. This data from the U.S. Census Bureau's American Community Survey represents no improvement from the 2004 level (10.1 percent).

Employment levels in CT have plummeted since the start of the recession in December 2007. One year since the CT economy began losing jobs, it has already shed 95 percent of the total jobs lost during all three years of the previous recession. CT lost 58,000 jobs, (3.4 percent decline in total jobs), between March 2008 and March 2009 (CT Department of Labor (DOL), April 2009. This level of job loss is similar to the national employment decline of 3.5 percent. The Initial claims for unemployment insurance jumped 75.5% from 16,268 to 28,551, the highest number since the 1991-1992 recession (The CT Economic Digest, January 2010).

I. Maternal and Child Health Indicators

I.A. Maternal and Child Demographics

In 2008, there were 40,106 births to CT residents. Of these births, 23,406 were to non-Hispanic White/Caucasian mothers, 5,017 were to non-Hispanic Black/African American mothers, and 8,662 births were to women of Hispanic/Latino ethnicity. Seventeen percent of the births to non-Hispanic White/Caucasian mothers, 57% of the births to non-Hispanic Black/African American

mothers and 54% of the births to Hispanic mothers were paid by public insurance. Thirteen percent of the births to Hispanic mothers were either self-paid or were uninsured vs. 2% for non-Hispanic White/Caucasian mothers.

Many maternal and child health indicators of health within CT compare favorably with the United States as a whole. High-risk groups experience a disproportionate burden of adverse health risk factors and outcomes. These disparities are documented in more detail in the Needs Assessment. To address racial and ethnic disparities in the state is a priority. Reducing the disparities in maternal and child health indicators remains one of the major challenges facing the public health community.

I.B. Infant Mortality

Approximately 260 babies die annually in CT, of whom about 200 die within the first month of life. Approximately 50% of these deaths are associated with low birth weight (LBW). Analysis of the 2000-2004 birth cohort, broken down into Perinatal Periods of Risk (PPOR) categories, indicates that fetal and infant deaths for babies of very LBW among non-Hispanic Black/African American mothers is nearly 4 times higher that that among non-Hispanic White/Caucasian mothers. Also significantly elevated are deaths to babies with higher birth weights.

The racial/ethnic disparity seen in feto-infant mortality rates reflects the consistently higher prevalence among the non-white population for risk factors, such as birth rates among teenage women, lack of adequate prenatal care, and low birth weight. Focusing prevention programs on groups showing a high rate of low and very LBW infants (such as women in the urban centers or the state's African American/Black population) may produce the greatest effect on reducing the overall risk factors among the nonwhite infant population in the state.

DPH programs intended to reduce infant mortality start before conception and continue through the prenatal and postnatal periods. Preconception interventions aimed at school-aged audiences and women of childbearing age include primary care services, health education programs, outreach and case-finding to link individuals and families to primary and preventive services. Efforts are focused on getting mothers into regular care early in the pregnancy and keeping both regular and specialty care appointments as directed by their health care provider. Postnatal efforts include medical testing for genetic disorders and maintaining good health for healthy infants and their mothers. Programs that include home visiting services funded by the Maternal and Child Health Block Grant (MCHBG) have been implemented to provide special care to pregnant women at high risk for adverse infant health. In 2009, DPH received federal funding to establish a Healthy Start community in Hartford, joining the New Haven Healthy Start program. These programs include outreach services to the Black/African American communities of the state.

I.C. Births to Teens

Teen birth rates in the state have decreased since calendar year 2000, but remained high in 2008 within the Hispanic/Latino community, where the teen birth rate was nearly ten times higher than that within the non-Hispanic White/Caucasian community. The teen birth rate within the non-Hispanic Black/African American community was over four times higher that that within the non-Hispanic White/Caucasian community. Among all the towns in CT, teen birth rate was highest within New Britain, where one in every 13 teen gave birth during the calendar year (birth rate 75.6 per 1,000). This rate was three times higher than the statewide average of 25.0 per 1,000 women, and nearly two times higher than the 2007 U.S. rate of 42.5 per 1,000.

Teen pregnancy is considered a public health problem for reasons related to the health of both the mother and newborn. Early sexual activity can result in a higher risk for sexually transmitted diseases, which could harm the fetus and impair the future fertility and health of the mother. Preventive interventions to address teen pregnancy through CT's Title V programs include programs to delay the onset of sexual activity, promote abstinence as the social norm, reduce the number of adolescents who have sex at young ages, and increase the number of sexually active

adolescents who use contraceptives effectively. Programs such as the Case Management Program for Pregnant Women and Parenting Teens, Healthy Choices, and Healthy Start (state and federal) serve pregnant and parenting teens. These programs provide case management services with emphasis on promoting positive pregnancy outcomes and positive parenting. The DPH FHS implemented a new Case Management for Pregnant Women program in three large cities with high rates of teen births. The program targets pregnant females and teens under the age of 20 who are at greatest risk for poor birth outcomes. This is a coordinated, culturally-sensitive approach to providing individualized client services through intensive case management and home visitation. The services are provided during the perinatal and interconceptional periods, with a focus on all aspects of achieving a healthy birth outcome, as well as building social supports, providing education, promoting birth spacing, family planning, referral to ongoing medical care, and building social supports promoting client self-efficacy.
The DPH recently submitted a grant proposal for funding in teen pregnancy prevention programs. If funded, the program will bring much needed intervention into high need communities, including the town of New Britain.

I.D. Prenatal Care
Early and regular prenatal care are protective factors against maternal and infant adverse outcomes, including infant mortality, low birth weight, and maternal complications. The Department has tried to improve access to prenatal care through strategies, such as supporting sites for primary care and free pregnancy testing at family planning clinics. At these sites, patients are referred for early prenatal care, in keeping with established protocols. Outreach services in Hartford through the recently funded Hartford Healthy Start program may help encourage pregnant women into early and regular care. Changes in the state's public insurance policies increased the eligibility limit for pregnant women to 250% of the federal poverty level (FPL) and provides presumptive eligibility to receive healthcare as the application is being processed, may encourage early entry into prenatal care. Coordination of home visiting services enhanced by the Patient Protection and Affordable Care Act of 2010 may also help to address early entry into prenatal care.

I.E. Low Birth Weight (LBW)
LBW (with weights less than 2,500 grams, or 5.5 pounds) is a major risk factor of infant mortality and long-term health problems. The impact of LBW on infant mortality occurs primarily during the first 28 days of life (the neonatal period), when LBW infants are about 32 times more likely than normal weight infants to die.

LBW rates among all singleton births in CT have not changed significantly since calendar year 2000. In 2008, low birth rate among non-Hispanic White/Caucasian mothers was 4.5 per 100 live births, 10.5 per 100 among non-Hispanic Black/African American mothers, and 6.5 per 100 live births among women of Hispanic/Latino ethnicity. LBW events were most concentrated in six towns: Hartford, New Haven, Bridgeport, Waterbury, New Britain, and East Hartford. Recent media campaigns focused on the African American and Hispanic communities of Hartford, New Haven and Bridgeport with funding from the federal First Time Motherhood Initiative. Additional efforts to address LBW in the state include a strategic plan within the FHS, state legislation to monitor LBW as a consequence of the recession, and a recent emphasis on LBW within the Women's Health Subcommittee of the Medicaid Managed Care Council, suggest that efforts surrounding LBW will continue in the future.

I.F. Maternal Depression
Information about maternal depression prevalence in CT is not readily available. Results of a point-in-time survey conducted in 2003, probed a variety of social risk factors for adverse births. The survey was conducted with women two to four months postpartum. Results of the survey revealed disparities in how women experienced their most recent pregnancy. Relative to non-Hispanic White/Caucasian women, three-times more non-Hispanic Black/African American women indicated that their pregnancy was one of the worst times in their life. These results do not explore the reasons why women of minority race and ethnicity experience more difficulty, but

recent publications indicate that social support structure is an important component to healthy maternal and birth outcomes. A new survey will be initiated within the next few months, and questions contained in the survey may further explore maternal depression in the state.
DPH contracted with Yale University to conduct training session of health care providers (obstetricians, family practitioners, pediatricians, social workers, nurses, mental health care professionals) about perinatal depression including perinatal risk factors, screening, diagnostic questionnaires, barriers to patient care, medications and service referral. This was a successful collaboration demonstrated by training 465 health care professionals in SFY 2008; toolkits were distributed to over 169 locations and 659 individuals that practices can use on an ongoing basis to educate, screen, and refer women and families. All Child Development Infoline (MCH Information and Referral Service) staff were trained regarding perinatal depression screening. Some practices and hospitals have adopted use of the screening tool as part of their assessment of pregnant women at their first prenatal visit. Trainings of health care professionals are continued in SFY10.

I. G. Oral Health
Dental caries (tooth decay) is an infectious disease process affecting both children and adults. During childhood, tooth decay is the single most common chronic disease, five times more common than asthma.

A 2007 oral health assessment of preschool (2-4 years old), kindergarten (5-6 years old and third grade (8-9 years old) students in CT determined the following: 1) dental decay is a significant public health problem for CT's children; 2) many children in CT do not get the dental care they need; 3) one in every 4 preschool children have experienced dental decay; 4) more than 60 percent of children in CT do not have dental sealants, a well accepted clinical intervention to prevent tooth decay in molar teeth; 5) there are significant oral health disparities in CT with minority and low-income children having the highest level of dental disease and the lowest level of dental sealants; 6) forty-one (41%) of third grade children have experienced dental decay and of those with decay experience, 18 percent have untreated decay.

The Office of Oral Health has initiated the Home by One program to build integrated partnerships with the early childhood community at the state and local levels that focus on oral health as essential to the overall health and well-being of children in CT.

I.H. Breastfeeding
Breastfeeding provides optimal nutrition for infants and is associated with decreased risk for infant morbidity and mortality as well as maternal morbidity (US Dept of Health and Human Services, Agency for Healthcare Research and Quality; 2007). Maternity practices in hospitals and birthing centers can influence breastfeeding behaviors during a period critical to successful establishment of lactation. All of CT's birth facilities have the option of reporting on the mother's intent to breastfeed. Since some mothers have not decided to breastfeed within twenty-four hours of birth, the hospital staff often leave this question unreported or report intent as "undecided".

CT has a Baby-Friendly hospital initiative in place and currently has three hospitals designated as Baby-Friendly. Baby-Friendly Designation is a globally recognized symbol of world-class maternity care, endorsed by the United States Breastfeeding Committee, the World Health Organization, and UNICEF. The pathway to designation provides maternity facilities the opportunity to improve health outcomes for mothers and babies; improve patient satisfaction, elevate reputation and standards of care, and increase market share; enhance a professional environment of competence; demonstrate a commitment to quality improvement; and build leadership and team skills among staff. All CT hospitals report breastfeeding data to the CDC's Maternity Practices in Infant Nutrition and Care (mPinc) project. DPH and CT Breastfeeding Coalition (CBC) assist the birth facilities through the initial discovery and development phase of the process. A program consultant will help the birth facilities complete at least five of the ten steps towards designation, by offering 40 hours of consultation with an International Board

Certified Lactation Consultant (IBCLC) with Baby-Friendly experience, and a two day training course. CT has an agreement with the Connecticut Breastfeeding Coalition through ARRA funding, to support ten (10) hospitals in earning the "Baby Friendly Hospital" designation.

In FFY09, the twelve regional CT WIC sites reported breastfeeding rates that exceeded the WIC goal of > 55%, yet only two of the twelve sites met or exceeded the HP 2010 objective of 75%. CT birth facilities require further education on adhering to the standard clinical practice guidelines against routine bottle supplementation when breastfeeding. Nine percent of CT hospitals have comprehensive breastfeeding policies as recommended by the Academy of Breastfeeding Medicine. Nine percent of CT hospitals provide patients with post-discharge telephone or opportunity for a follow-up visit. DPH's Immunization Program now includes breastfeeding educational materials in the hospital discharge packet in all birth facilities. The information provides contact information for support and referral.

Most WIC nutrition staff are Certified Lactation Counselors (CLC), trained to provide individualized support for breastfeeding mothers and each site has a dedicated Breastfeeding Coordinator to provide breastfeeding support, education and referrals. CT WIC continues to provide annual training for nutritionists to become CLCs and renew their certification.

The CT WIC program has expanded the Hispanic Health Council/Hartford Hospital Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program to Yale-New Haven Hospital (YNHH). YNHH has a number of breastfeeding initiatives underway that demonstrate its unique suitability for successfully implementing a breastfeeding peer counseling program, including: initiation of a breastfeeding clinic, providing an alternate location for peer counselors to meet with their clients to provide follow up and support, with access to a Lactation Consultant or physician, integration of the peer counseling program into the administrative structure of the Yale Primary Care Center (PCC) as well as inpatient maternity services. The Yale PCC serves largely African American individuals and this segment of the population has lower breastfeeding duration rates that its White or Latino counterparts. The provision of this evidence-based service to the YNHH population is consistent with national and state health objectives to reduce or eliminate racial and ethnic disparities.

I.I. Obesity

Obesity is the second leading cause of preventable death in the United States after smoking (Wee, American Journal of Public Health, 2005). According to the 2008 Pediatric Nutrition Surveillance System, which assesses weight status of children from low income families participating in WIC, 31.2% of low income children age 2-5 are overweight or obese in CT. One in four (26%) CT high school students are obese (12.3%); are overweight (13.3%) (2007 YRBS). Adolescents who are overweight have an 80% chance of being obese as adults. One in five CT high school students (21.5%) eats the recommended five or more daily servings of fruits and vegetables (2007 YRBS).

I.J. Immunizations

The Immunizations Program distributes vaccines to providers throughout the state, conducts surveillance for vaccine preventable diseases, conducts quality assurance reviews for vaccines for children programs, conducts educational programs for medical personnel and the public, works with providers using the immunization registry to assure that all children in their practices are fully immunized, promulgates rules and regulations related to vaccination requirements for day care, schools, colleges and universities. Beginning August 1, 2010 all incoming CT college freshman (full-time or matriculating) will be required to show proof of 2 doses of measles, mumps and rubella vaccine and 2 doses of varicella (chickenpox vaccine). Beginning September 1, 2010 all children born on or after January 1, 2009 who attend a child day care center, group day care home, or family day care home ages 12-23 months are required to have one dose of the Hepatitis A vaccine; two doses are required for those aged 24 months and older. By January 1, 2011 and each January 1 thereafter, children aged 6-59 months attending a child day care center, group day care home, or family day care home are required to receive at least one dose of influenza

vaccine between September 1 and December 31 of the preceding year. The Immunization's staff facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations.

II. Other Indicators

II.A. Socioeconomic Indicators in CT

CT is a small state of about 5,000 square miles and 169 towns, with a July 1, 2008 estimated statewide population of 3,501,252. The average town size is about 20,000, and only five towns have a size greater than 100,000. These five towns are Bridgeport (population 136,405), Hartford (124,062), New Haven (123,669), Stamford (119,303), and Waterbury (107,037).

41 towns had high unemployment rates reported in 2008, with Hartford having the highest at 10.9%. Eighteen towns with high unemployment rates had populations that exceeded the average town size. These data indicate that the need for social services in the state is not limited to towns of high population.

II.B. Health Care Delivery Environment in Connecticut

CT's direct health care services are delivered through a range of providers including, but not limited to, school based health centers (SBHC), community health centers (CHC), outpatient clinics, physicians offices for primary care services; free-standing and hospital-based outpatient surgical centers for diagnostic or minor surgical procedures; acute care hospitals for emergency care, routine outpatient or inpatient services; long term care facilities for chronic care or rehabilitative service; and increasingly non-institutional settings, such as the home, for services ranging from intravenous infusion of medications to physical therapy. To date, 11 "Minute Clinics" have been established at local CVS pharmacies. These clinics are staffed with licensed Nurse Practitioners and Physician Assistants and serve clients ages 18 months of age and older. The licensure or certification of health care facilities and health care professionals guides delivery of health care and services. Utilization of services is dependent upon a variety of demographic, economic, social and environmental factors, all of which are considered when planning the delivery of Title V programs, services and activities.

Perinatal Care in CT is provided through a network of Healthy Start Providers. The goal of the state Healthy Start Program is to promote positive birth outcomes and maternal and infant health among at-risk, low-income families in CT. To complement the Healthy Start program, CT also has a Nurturing Families Network, which operates in all 29 birthing hospitals in the state. It provides parent education and support for first time parents. Unlike the Healthy Start program, families are enrolled in the Nurturing Families Network when they are expecting or have just given birth to their first child.

II.C. Safety Net Providers

Safety Net Providers are part of the system of care that addresses the needs of individuals who experience barriers when accessing the traditional health care system. Some of these barriers include financial, transportation, cultural and linguistic differences, etc. Populations targeted by safety net providers include uninsured, underinsured, immigrants, and the homeless. The safety net providers in CT include CHC, SBHC, Visiting Nurse Associations (VNA), Local Health Departments (LHD) and Family Planning Clinics. In the past year, federal stimulus funding allowed community health centers to cover costs associated with treating additional patients, develop infrastructure, and allowed existing CHC to add sites. Three CHC obtained 330 Federally Qualified Health Center (FQHC) funding (Community Health and Wellness Center of Greater Torrington, Norwalk Community and Family Services, Inc., and the Greater Danbury CHC). State bonding dollars have been made available to CHC and SBHC to continue to build their capacity as a safety net provider.

II.D. Health Insurance

As of May 2009, 9,671 CT residents were enrolled in the Charter Oak Plan (CT's universal health coverage plan, available to all consumers on an income-based sliding scale). Another 4,927 were eligible but not enrolled.

HUSKY (Healthcare for UninSured Kids and Youth) is CT's health insurance plan for children and families. In 1997 when the federal government created the State Children's Health Insurance Program, CT renamed part of its Medicaid program that serves children and low-income families "HUSKY A" and established the "HUSKY B" program for uninsured children with family income that exceeds the HUSKY A limits. HUSKY A and B are managed care programs, administered through the Department of Social Services (DSS) and private health plans. HUSKY A covers pregnant women (with income under 250% of the FPL and children in families with income under 185% of the FPL. Parents and relative caregivers can also obtain comprehensive benefits. The basic HUSKY package includes preventive care, outpatient physician visits, inpatient hospital and physician services, outpatient surgical facility services, short-term rehabilitation and physical therapy, skilled nursing facility care, home health care and hospice care, diagnostic x-ray and laboratory tests, emergency care, durable medical equipment, eye care and hearing exams.

Mental and behavioral health services; and dental services are carved out and administered through Administrative Service Organizations (CT Behavioral Health Partnership, and CT Dental Health Partnership). Pharmaceuticals are administered directly through the Department of Administrative Services.

HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. As part of HUSKY B, HUSKY Plus provides supplemental benefits for Children and Youth with Special Health Care Needs enrolled in HUSKY B. Services include Multidisciplinary teams (Pediatricians, Advanced Practice Nurses, Benefits Specialists, Family Resource Coordinators and Advocates) who work with families to identify their child's care needs and the resources to meet those needs. Community-based mental health and substance abuse services to children and youth with intensive behavioral health needs are also offered under HUSKY Plus.

HUSKY gives families the flexibility to choose one of three participating managed health care plans: Aetna Better Health, AmeriChoice by United Healthcare, or Community Health Network of CT.

A fee for service option, HUSKY Primary Care, Connecticut's Primary Care Case Management (PCCM) program, is now available to HUSKY A members in the Hartford, New Haven, Waterbury, and Windham areas. In HUSKY Primary Care, the primary care provider has a greater role in coordinating health care on a Per Member Per Month (PMPM) reimbursement basis. The providers in HUSKY Primary Care offer the same services offered by a managed care health plan, such as health education, reminders about immunizations and well-child visits, and help in scheduling appointments.

There are 378,571 persons, including 249,156 children under 19 enrolled in HUSKY A as of June 1, 2010. HUSKY B provides health care for children without employer-sponsored coverage for a sliding fee. There are 15,476children under 19 in HUSKY B as of June 1, 2010 (CT Voices for Children; web site www.ctkidslink.org).

DPH has provides policy guidance and technical assistance to the HUSKY program through:

- DPH medical home care coordination, extended services, and respite fund administration contractors provide benefits coordination for families of Children and Youth with Special Health Care Needs (CYSHCN) to assist in accessing public/private sources to pay for services needed.
- Participation in the Covering CT's Kids coalition, a network of organizations involved in HUSKY outreach (including DSS, and MCH Information and Referral Service),
- Partnering in the work to expand Katie Beckett waiver and other related DSS waiver applications to support access to comprehensive care for children and youth,

- Working with the State Medicaid Managed Care Council to promote outreach for prenatal access in first trimester and Medicaid reimbursement of care coordination services to improve access to pediatric primary health care under Early Periodic Screening and diagnostic and Treatment Services,
-Working to facilitate access to PCCM as well as to the Medicaid Managed Care plans.
- Working with the State Commission on Children, HUSKY and other CT key stakeholders in promoting home visitation for mothers with newborns, particularly at risk mothers using Healthy Start and Nurturing Families Programs,
- Providing care coordination and respite care as well as family support services to children with special health care needs in HUSKY.
- Developing linkages between HUSKY and state public health programs such as WIC, childhood immunizations, Medical Home Learning Collaborative of primary care physicians, SBHC, CHC, Family Support Council, and other essential community services and Title V funded programs.
- Utilizing existing services to create access points for referral or applications to enhance outreach and enrollment; and
- Implementing quality improvement activities and evaluation.

II.E. Racial and Ethnic Disparities

In 2007, the Hispanic or Latino population comprised 11.5% of the CT population. Hispanics represented 35.1% of uninsured CT adults (2004-2006 CT BRFSS). Hispanics represented 17.5% of all reported Chlamydia cases (2001-2005). Hispanics represented 35.1% of all reported HIV/AIDS cases (2001-2005). In 2005, about 22% of Connecticut doctors reported that they felt unprepared to treat patients with limited English proficiency (Hispanic Health Council 2006, 31-32).

Among the Black/African American population, age-adjusted death and premature mortality rates of Black/African Americans CT residents are significantly higher than those of the White, non-Hispanic Connecticut residents for the following leading causes of death - heart disease, cancer, cerebrovascular disease, HIV, and diabetes (2000-2004 data). African Americans have 1.2 times the age-adjusted death rate for all causes, 1.2 times the age-adjusted death rate for heart disease, 1.1 times the age-adjusted death rate for cancer, 1.4 times the age-adjusted death rate for cerebrovascular disease (stroke), 2.5 times the age-adjusted death rate for diabetes, and 14.9 times the age-adjusted death rate for HIV/AIDS compared with White, non-Hispanic CT residents. (The CT Health Disparities Report, 2009)

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation.

The DPH Office of Multicultural Health (OMH) is responsible for providing leadership in promoting, protecting, and improving the health of all CT residents by eliminating differences in disease, disability, and death rates among ethnic, racial and culturally diverse populations. The Office promotes access to quality health education and health care services; facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. OMH functions largely through collaboration with statewide partners, and recommends policies, procedures, activities, and resource allocations to improve health among the states' underserved and diverse populations, and to eliminate health disparities.

OMH leads state and local partners in addressing multicultural health issues and eliminating health disparities by focusing on the goals of: 1) Improving Language proficiency; 2) Promoting Cultural Competency; 3) Increasing Workforce Diversity; and 4) Enhancing Awareness, Access to Health Care and Health Education.

II.F. Rural Health

The CT definition of rural uses the 2000 U.S. Census data and OMB designations. All towns in a designated Micropolitan Statistical Area with a population less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000 are designated rural for the State of CT. Of the 169 towns in CT, there are 52 with populations of less than 7,000 as of 2008. Specific concerns identified for rural CT include: emergency medical services, transportation, recruitment and retention of adequate workforce, a decreasing social services safety-net, mental health, oral health, and others. Currently there are 7 of CT's rural towns, which are designated as Medically Underserved Areas/Populations (MUA/Ps). The Title V program will continue to support the Primary Care Office (PCO) now located in the Family Health Section (FHS), to continue to assess and designate Connecticut's rural communities collaborating with the ORH. The DPH has representation on the Office of Rural Health (ORH) Advisory Board.

The CT ORH identifies data sources, analyze and report the key health care issues impacting rural CT. The overall goal is to gain a better understanding of the health status of rural residents and develop a supporting rural health database. Results from a survey indicated concerns regarding transportation service in rural communities, adequate services for substance abuse, domestic violence, oral health care and mental health services. The report can be found at www.ruralhealthct.org/report.htm.

CT DPH Injury Prevention Program and MCH staff are collaborating with the CT-ORH on the Region 1 Rural Injury Community of Practice initiative facilitated by the Children's Safety Network. An analysis of rural and non-rural injury-related mortality and hospitalizations for leading causes of injury was recently completed. The next step is to look at additional sources of data on rural injuries, identify existing prevention efforts/partnerships and develop a rural focus for these efforts as needed.

II.G. Other Vulnerable Populations

DPH is interested in the health needs of vulnerable women and children, many of whom face financial, language, and cultural barriers to care. These populations include the uninsured, single mothers transitioning from welfare to work, homeless mothers and children, incarcerated women, adolescents who are concerned with confidentiality (parent involvement in their health care), and immigrant and undocumented populations. Safety net providers, such as community health centers and school based health centers, as well as case management programs, help address the needs of vulnerable populations.

Incarcerated Women's Health: The DPH collaborated with DOC and a community-based agency to continue to provide intimate partner violence/trauma training to inmates onsite at York Correctional Institute (YCI), CT's only female prison. In addition, plans are underway to provide this training to recently released women at halfway houses and resettlement programs. The goal is to help this vulnerable population understand what intimate partner violence is, prevent repeated trauma, seek appropriate resources and supports, and develop healthy relationships.

Male Involvement: The FHS recognized that the health of fathers and men impacts the health of women, children and families. The Title V Program is an active participant on the DSS Fatherhood Initiative Council that develops and disseminates consumer and provider educational materials regarding the importance of men's health and the impact on maternal and child health. This workgroup is comprised of members from DCF, DSS, DOC, and community based organizations. DPH is contracting with Real Dads Forever, Inc. who will pilot, conduct and evaluate a train-the-trainer training of its recently developed health education curriculum for male partners to providers in the Hartford Healthy Start Program. The goal of the training to men is to increase involvement between fathers/family men ages 15 through 30+, single or married, and their children. The training will provide strategies directed at male partners to support women during pregnancy by providing strategies that reduce stressors in their relationships and that positively impact lifestyles in support of the child.

DPH supports and partially funds the annual New England Fatherhood Conference, which

reaches out to birth fathers, fatherhood practitioners, child welfare leaders, and community-based staff workers to participate in the conference and share information in both formal and informal venues.

DPH also was a signatory in a Memorandum of Understanding among the State Departments of Social Services, Children and Families, Mental Health and Addiction Services, Correction, Labor, and Education, and the Judicial Branch to collectively develop an annual report to be presented to the Fatherhood Advisory Council to provide information on expenditures and programmatic/statistical activities.

III. Health Priorities

III.A. MCH Priorities
The nine identified state priority needs are: 1) Enhance Data Systems; 2) Improve Mental/Behavioral Health Services; 3) Enhance Oral Health Services; 4) Reduce Obesity among the three target MCH populations; 5) Early Identification of Developmental Delays, Including Autism; 6) Improve Health Status of Women, particularly related to depression; 7) Improve Linkages to Services/Access to Care; 8) Integrate the Life Course Theory throughout all state priorities; and 9) Reduce Health Disparities within the three MCH target populations

III.B. CYSHCN Priorities
The DPH requires that the CYSHCN community based networks: 1) operate programs that are family-centered with family participation and satisfaction; 2) perform early and continuous screenings; 3) improve access to affordable insurance; 4) coordinate benefits and services to improve access to care; 5) participate in spreading and improving access to medical home and respite services; 6) participate in developing the community-based service system of care, and 7) promote transition services for youth with special health care needs. Emphasis is placed on family education and in building care coordination capacity within provider practices.

DPH is the state's lead agency for implementation of the State Early Childhood and Comprehensive System's (SECCS) grant, called Early Childhood Partners (ECP), which supports all CT families to ensure that children arrive at school healthy and ready to succeed. ECP has collaborated with the Children's Trust Fund to build provider capacity as it relates to identifying and referring children with developmental delays. ECP funds are leveraged to conduct annual Ages and Stages Questionnaire (ASQ) trainings for health care providers.

DPH is a board member of the CT Association for Infant Mental Health (CT-AIMH). CT-AIMH promotes social emotional health and development of infants, young children and their families.

III.C. Data and MCH Impact
Consistent with the HP 2010 objectives, CT gives priority to MCH surveillance through the creation of a comprehensive linked database containing high-quality, record-level, child health data (HIP-Kids), a database for CYSHCN, Fetal and Infant Mortality Review, and Vital Records data collection and analysis. The HIP-Kids database project is located in the FHS and holds information of newborns on lab screening tests, hearing tests, and birth defects reported by birth facilities through the electronic reporting system. The HIP-Kids project is being migrated to a web-based application called MAVEN and includes a planned electronic link to the Electronic Birth Record followed by a link to the death record system. All Title V activities and programs are designed to promote and protect the health of CT's mothers, children and adolescents, and children with special health care needs.

Additional activities include the completion of the PRATS survey in 2009 to obtain information about the experiences and health behavior of pregnant women before, during and after their most recent pregnancy. The first Birth Defects Registry Report for 2001-2004 has been released and is posted on the DPH website. The Birth Defects Registry submitted data on 6/18/10 to the Centers for Disease Control (CDC) and National Birth Defects Prevention Network for children

born in 2007 in June 2010. The 2005-2007 registry report has data for children born with 45 reportable birth defect conditions. Data for year 2008 is being analyzed and will be published in 2011. The Birth Defects Registry is working closely with the Environmental Public Health Tracking System and has submitted birth defects data through the birth cohort 2007.

The birth defects epidemiology staff received notification that the New England Genetics Collaborative (NEGC) Innovative Project Awards, 2010-2011 application for the Development & initiation of a New England Birth Defects Consortium (NEBDC) was funded for a second year in June 2010. New Hampshire is the lead in this six-state consortium. The Consortium is working to: 1) Implement routine data sharing among member states; 2) Support research into the causes of birth defects in New England; and 3) Prevent Birth Defects in New England by engaging members in a pilot project to standardize a prevention campaign among all states in the NEBDC.

The need to strengthen data linkages was identified in the five-year needs assessment. The Title V program will be taking a lead role in securing a contract with the CT Hospital Association to obtain hospital discharge data. The acquisition of this data set will enhance case ascertainment for the maternal mortality surveillance program, enhance the Crash Outcome Data Evaluation System (CODES) database and provide additional data for the Asthma and other MCH programs both at the state and local levels. A data management module for the in-patient hospitalization and ED data was created and will be placed on DPH's Public Health Information Network (PHIN) to facilitate the creation of data extracts for various DPH programs that have requested access to this secondary data source. In-patient hospitalization & ED data for its placement on PHIN was provided. Under the authority of the DPH Commissioner, all 31 acute care hospitals are now required to submit annual in-patient hospitalization & Emergency Department (ED) data to the agency starting with the CY 2006 & 2007.

In March 2009, an MOU was signed between DPH and the Department of Developmental Services (DDS). The purpose of this MOU is for early detection and intervention for infants with hearing impairments, or with other medical conditions that have a high probability of resulting in developmental delay. The Birth Defects Registry monthly identifies children born weighing less than 1,000 grams and/or born at 28 weeks gestation or less with the Birth to Three System.

IV. Conclusion

It is the role of CT's Title V program, through funding of direct/enabling, population-based, and infrastructure building services, to address prioritized needs and gaps in services for the target populations. Community based programs are funded to provide direct and enabling services, such as case management and outreach. Population-based services include disease prevention and education. Infrastructure building services include needs assessment, policy development, quality assurance, development and management of information systems, and training.

The Title V Program determines factors that impact services in the State, through: 1) conducting statewide assessments (MCH five-year needs assessment); 2) reviewing and analyzing Title V programs quarterly reports submitted by all contractors, which include quantitative and qualitative information; 3) technical assistance meetings with the MCH contractors; 4) analyzing data from various sources; and 5) continuous feedback from stakeholders through advisory groups.

The Title V Program has taken a more data driven approach to its prioritization of MCH program design and implementation, and is committed to use resources effectively to address health disparities. As a result, the need to enhance our data collection system and integrate information becomes very apparent to support continued assessment, evaluation, research, and development of public health policy for the MCH population.

B. Agency Capacity

Authority for the Maternal, Infant, and Child and Adolescent Health Programs is derived from the CT General Statutes and Title V Federal Grant Program Requirements. The following describes the statutes that support DPH authority for MCH programs.

The statutory basis for maternal and child health services in Connecticut originates from the statute passed in 1935, SS19a-35 PA 35-240 authorizing the Department of Public Health to receive Title V funds for its existing maternal and child services. Statute SS19a-59b PA 83-17(1983) established the Maternal and Child Health Protection Program (MCHPP) to provide outpatient maternal health services and labor services to needy pregnant women and to children less than 6 years of age; and SS19a-7i PA 97-1 (1997) extended coverage under the Maternal and Child Health Block Grant.

Statutes passed to provide maternal and child care include: SS19a-7c PA 134(1990) subsidized non-group health insurance for pregnant women; SS19a-90 PA 41-255(1941) blood tests of pregnant women for syphilis; SS19a-59c PA 88-72(1988) special supplemental food program for women, infant and children (WIC); SS19a-59a PA 82-355(1982) low protein modified food products and amino acid modified preparations for inherited metabolic disease; SS19a-55 PA 65-108(1965, 2002) newborn infant screening; SS19a-59 PA 81-205(1981) newborn infant screening for hearing impairment; SS19a-49(1961) and SS19d-55b PA 09-21(2009) screening and care for infants and children for cystic fibrosis; SS19a-7f PA 91-327(1991) and SS19a-7h PA 94-90(1994) childhood immunization schedule and registry; SS19a-54 PA 33-266(1933) and SS19a-52(1981) physically handicapped children registration and equipment; SS19a-53 PA 33-318(1933) childhood physical defects; SS19a-50 PA 39-142 PA 37-430(1937, 1939) and SS19a-51 PA 63-572(1963) children crippled or with cardiac defects; SS19a-48(1949) care for children with cerebral palsy; SS19a-53 PA 33-318(1933) physical defects of children; SS19a-56a PA 89-340(1989) and SS19a-56b PA 89-340(1989) birth defects surveillance and confidentiality; SS19a-60 PA 45-462(1945) and SS19a-38 PA 156(1965) dental services for children and fluoridation of public water; SS19a-110 PA 71-22(1971) lead poisoning; SS19a-62a(2000) pediatric asthma; and SS47-48 PA 06-188(2006) Medical Home Pilot Program

Other statutes exist to provide regulatory authority for Title V related services that include: SS10-206 PA 04-221(1940-2004) health assessments of school pupils; SS14-100a PA 05-58(2005) child restraint systems; SS19a-7a PA 90-134(1990) availability of appropriate healthcare to all CT residents; SS19a-4j PA 98-250(1998) addressing disparity of disease in racial, ethnic, and cultural groups; SS19a-4i PA 93-269(1993) injury prevention; SS19a-7 PA 75-562(1975) public health planning; SS19a-17b PA 76-413(1976) peer review; SS19a-25 PA 61-358(1961) confidentiality of records; SS4-8 (1949) transfer Title V funds to Department of Social Services; SS19a-32(1949) authority to receive, hold, invest, and disperse assets; SS19a-2a PA 93-381(1993) powers and duties of Commissioner of DPH in the prevention and suppression of disease; SS51 PA06-195 to establish a School Based Health Center ad hoc committee.

Program Capacity in CT

The mission of DPH is to protect and improve the health and safety of the people of Connecticut. Within DPH, the Family Health Section (FHS) is part of the Public Health Initiatives (PHI) Branch. The FHS is comprised of five units: 1) Primary Care and Prevention, 2) Children and Youth with Special Health Care Needs, 3) Program Development, 4) Immunizations, and 5) Registry.

The focus of programs within the FHS is to promote community based, coordinated, culturally competent, family centered services to pregnant women, mothers and infants, children and adolescents (including CYSHCN) through the life course. Staff within the units work collaboratively to coordinate resources and maximize program capacity.

Programs supported with MCH Title V funds provide direct services, enabling services, population based services and/or infrastructure building services. CT's Title V Program focuses on three main populations: 1) Pregnant Women, Mothers and Infants (PWMI), 2) Children and

Adolescents (CA), and 3) Children and Youth with Special Health Care Needs (CYSHCN).

Title V Partnership Programs for Pregnant Women, Mothers and Infants

Breastfeeding Initiative: DPH is developing internal mechanisms and evaluating capacity to collect population-based breastfeeding data. The Electronic Newborn Screening Database collects data from all birthing hospitals on the mother's intent to breastfeed.

Case Management for Pregnant Women: provides comprehensive, integrated case management services during the perinatal and interconceptional periods to pregnant and post partum teenagers and women in an effort to improve birth outcomes. The program is offered in three towns/cities and includes the partners of pregnant women.

Centering Pregnancy: Two Centering Pregnancy programs in New Haven provide services to women who are most at-risk for delivering low birth weight infants, so as to achieve outcomes that include: 1) empowerment and community-building among pregnant group members, 2) increased satisfaction of pregnant women with prenatal care, 3) reduction in premature or preterm births, and 4) increased breastfeeding of infants by their mothers. The Centering Pregnancy model includes three "care components" of assessment, education, and support, which are provided within a group setting and facilitated by a credentialed health provider and a co-facilitator.

Community Health Centers receive state funds to provide primary and preventive health services across the lifespan.

Family Planning: promotes decreasing the birth rate to teens, age 15-17, preventing unintended pregnancy, and increasing access to primary reproductive health care. Through its contract with Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.), comprehensive reproductive health services are available in 12 locations with 4 subcontractor locations across the state.

Fetal and Infant Mortality Review (FIMR): to identify and address contributing factors to fetal and infant mortality. The state budget did not include funding for the FIMR program in state fiscal year 2010. Funding to the former FIMR contractors was restored in State fiscal year 2011.

Healthy Choices for Women and Children (HCWC): provides intensive case management services to low income, pregnant and postpartum women in the City of Waterbury or surrounding communities, who abuse or are at risk for abusing substances (or whose partner abuses substances), and their children from birth to age three. Services include case management with intensive home visiting, prevention education, parenting education, domestic violence, planning, and assistance with housing and transportation.

State Healthy Start: provides case management services to eligible pregnant women for the purpose of 1) improving CT birth outcomes by reducing the rate of infant mortality, morbidity and low birth weight, 2) providing access to prenatal/postpartum care services through CT's HUSKY A healthcare program, and 3) promoting and protecting the health of both mother and baby. This program is offered through a MOA with the DSS.

Federal Healthy Start Program: designed to increase the number of low-income black African American pregnant women who enter early prenatal care to promote healthier pregnancies and reduced rates of birth complications such as infant morbidity and mortality. DPH secured federal funding to address racial and health disparities in the city of Hartford.

Maternal and Child Health Information and Referral Service: administers the toll-free MCH hotline that provides information on health and related services. Services are accessible to non-English speaking callers and to speech/hearing impaired callers. DPH contracts with the United Way of

CT for the service.

First-Time Motherhood/New Parent Initiative: an Infant Mortality Social Marketing Campaign in Hartford, New Haven, and Bridgeport to increase awareness of and linkages to existing preconception/interconception, prenatal care and parenting resources as well as to increase the likelihood of a healthy pregnancy. The HRSA grant supporting this initiative ends August 2010.

The Office of Oral Health works with the American College of Obstetrics and Gynecology and the March of Dimes to address oral health during the prenatal period.

The 2007-2011 State Systems Development Initiative (SSDI) Project goals are to: 1) improve and increase the availability of quality data for the MCHBG and MCH programs, and 2) develop data dissemination systems of analytic reports and presentations to help inform public health programs at the state and local level.

CT is focusing on 3 main activities to achieve these goals: 1) implementing HIP-Kids, a comprehensive linked database containing high-quality, record-level, child health data; 2) linking birth records with WIC enrollment and visit data, and to include a linkage with the state Medicaid eligibility files; and 3) conducting a PRAMS-like survey of postpartum women in CT.

Injury Prevention: focuses on the "reduction of the factors associated with intentional, unintentional and occupational injury". The Injury Prevention Program, following National recommendations for intentional and unintentional injury prevention, conducts community-based programs to address risk and resiliency factors and implements strategies to decrease injury.

Title V Partnership Programs for Children and Adolescents, Age 1 - 22 years

Healthy Start: As described above.

School Based Health Centers (SBHC): DPH funds 75 SBHC in 23 communities. Licensed as outpatient facilities or hospital satellites, they offer services addressing the medical, mental and oral health needs of youth.

Expanded School Health Services (ESHS): DPH funds 3 ESHS projects at 10 sites. One site focuses on preventing and improving mental health status and service referral for children and youth in a regional school system, and one site provides access of physical and behavioral health services to preschool children and families who are at risk for learning. An additional ESHS program provides mental health and dental services to students in eight elementary schools in a high need community.

Family Planning: A special effort is made to target services to teens and provide STD screening and treatment, HIV/AIDS screening, and contraception services. Other services include free pregnancy tests and counseling for adolescents at or below 150% federal poverty level, outreach, teen life conferences, reproductive health and STD prevention literature, and community educational programs to teens at risk.

Healthy Choices for Women and Children (HCWC): As described above.

Maternal and Child Health Information and Referral Service (MCH I&R): As described above.

Case Management for Pregnant Women: As described above.

The Early Childhood Partners (ECP) Initiative: funded through the HRSA Early Childhood Comprehensive Systems Grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. ECP efforts include expanding the number of pediatric practices and clinics providing medical homes

for all children and especially CYSHCN; increasing the number of parents and providers trained and participating in their communities as advocates for children; meeting the developmental needs of children through access to comprehensive health, mental health and education consultation for families and early care and education providers; and meeting the developmental needs of children through the increase of perinatal depression screenings among postpartum mothers. The CT Early Childhood Cabinet serves as the State Advisory Council on early education.

The DPH Injury Prevention Program (DPH-IP): The CT Young Worker Safety Team, a collaboration of DPH and State Departments of Labor and Education, federal and local agencies, promotes safety of adolescents in the workplace through awareness, education and training activities. DPH-IP collaborates with partners to facilitate the Interagency Suicide Prevention Network, and participates in the Youth Suicide Advisory Board.

Title V Partnership Programs for Children with Special Health Care Needs

The CYSHCN program provides care coordination, advocacy and family support to CYSHCN regardless of enrollment financial status. A review of the CYSHCN program resulted in a new infrastructure and capacity building strategy to meet the Healthy People 2010 goals of parent partnership, comprehensive care within a medical home, adequacy of insurance, screening for special needs, community-based systems and transition to all aspects of adult life. There are an estimated 133,000 CYSHCN in CT.

The DPH Medical Home Advisory Council (MHAC), comprised of more than 40 representatives, including youth representation from Connecticut Kids as Self Advocates (CT-KASA), from state and private agencies, community-based organizations and parents of CYSHCN, provides guidance to DPH in its efforts to improve the system of care for CYSHCN by ensuring their connection to a medical home.
The Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs: enhances capacity for medical homes in the five state regions to screen children; and assists medical homes through community-based health care systems while enhancing access to services. The five networks providing co-located and/or embedded care coordination on a regional basis are: 1) CT Children's Medical Center (north central), 2) St. Mary's Hospital (northwest), 3) Stamford Health System (southwest), 4) Coordinating Council for Children in Crisis, Inc. (south central), and 5) United Community and Family Services, Inc. (eastern). Services include: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Children with an identified chronic condition and are either uninsured or underinsured may be eligible for payment of durable medical equipment, prescriptive pharmacy and special nutritional formulas through CYSHCN/CMHI. The CYSHCN program offers a limited respite program based on available funds, and transition services to adult care. The CT Lifespan Respite Coalition is the statewide administrator of extended services and respite funds for CMHI, and serves as an additional statewide point of entry.

CYSHCN program surveillance, planning and evaluation: DPH epidemiology staff developed a Microsoft Access database to assure that information was collected and the database is utilized by each of the five regional care coordination networks. DPH is working with developers to migrate the CYSHCN database to a web-based platform. This will allow for integration of data with other databases at DPH, and allow for future connection to Electronic Medical Records. The system will allow information from families; medical home based care coordinators, and other stakeholders to be integrated.

The United Way's (2-1-1) (the MCH Information and Referral Service) Child Development Infoline (CDI): serves as a statewide point of entry to CMHI and for information and resource referral for CYSHCN. CDI caseworkers make referrals to the CT Birth to 3 System, Help Me Grow,

Preschool Special Education, and/or CYSHCN/CMHI. The 2-1-1component of MCH Information and Referral Service works closely with the CMHI on their resource information updates.

The Child Health and Development Institute (CHDI): provides a statewide family outreach and education component of the CMHI with a focus on Family/Professional Partnership. Family/Professional partners provide training to families in linking to resources, and work in partnership with primary care providers.

Adult and Maternal Phenylketonuria Program (PKU): The 2 Regional Genetic Treatment Centers (UConn Health Center (UCHC) and Yale) maintain current records on all adolescent and adult females in CT with PKU, and serve as genetics consultants for primary care providers throughout the state. Genetic and nutritional counseling and high-risk pregnancy care is provided to adolescent and adult females in CT with PKU.

Genetics: The 2 Regional Genetic Treatment Centers provide access to genetic services for all residents. These services include confirmation testing for newborns identified with abnormal metabolic screening results, prenatal testing, genetic counseling, and ongoing treatment, support for adults with PKU, and high risk pregnancy care for the maternal PKU clients.

Oral Health: The Office of Oral Health addresses the oral health needs of CYSHCN through health promotion activities, particularly early childhood caries prevention. Oral health promotion and disease prevention is an integral part of the goals, objectives and educational activities of the CYSHCN program The Home by One Program partners with DDS and the Family Support Network to implement oral health educational activities of the CYSHCN program.

Pregnancy Exposure Information Services (PEIS): a toll-free telephone line supported by the UCHC Genetics Program. During 2009, this line provided information to 841 pregnant women who were concerned about exposure to toxic substances during pregnancy and the possible effect(s) to their baby.

School Based Health Centers: provide primary and preventive physical and behavioral health care to CYSHCN who are mainstreamed in school settings. SBHC coordinate care with a child's primary physician and/or specialist.

The Sickle Cell Disease Community Outreach and Support Program: services include Sickle Cell Disease education, screening, trait testing and referral, and case management services including: advocacy, family support, systems navigation, and transition services. The program is contracted to the Hospital for Special Care, which collaborates with providers and hospitals to facilitate access for individuals with Sickle Cell, and subcontracts with The Sickle Cell Disease Association of America Southern CT Chapter and Citizens for Quality Sickle Cell Care.

Universal Newborn Screening (UNBS): a population-based program to test, track and treat all newborns. All newborns are screened for the disorders as listed in the document attached to this section, "CT Newborn Screening Panel." Infants with abnormal screening results are referred for comprehensive testing and treatment services. Counseling and education are provided to the parents of these children. The program provides increased public health awareness of genetic disorders, public health education, and referrals.

Universal Newborn Hearing Screening (UNHS): All 31 CT birthing facilities participate in a legislatively mandated UNHS program. Standardized equipment is used to screen all newborns prior to discharge. Hospitals notify the primary care providers of all infants in need of follow-up audiologic testing. Tracking and follow-up of children are conducted at the state level. A web-based reporting system tracks screening results from the birth hospitals. A database is used to track infants referred to audiologists for further evaluation. Those with hearing loss are enrolled in the CT Birth to Three Program. The Early Hearing Detection and Intervention (EHDI) program works with eleven diagnostic audiology centers that provide follow-up testing from the hearing

screens conducted at birth.

Cultural Competency

The Title V programs have incorporated contract language that requires providers to deliver culturally competent services and demonstrate this by: developing a mission statement committing to cultural diversity, develop materials in languages reflecting the needs of the patient population, policies and procedures to address the needs of the patient population, taking into account factors such as race, ethnicity, age, gender, hearing impairment, visual impairment, physical disability, mental illness, developmental disability and sexual orientation. The Title V Program will continue to address health disparities based on data by race and ethnicity to identify and allocate resources.

The Office of Multicultural Health (OMH) promotes access to quality health education and health care services, facilitates presence of diverse populations in health planning, program development, policy formation, and outreach and awareness initiatives. The OMH functions largely through collaboration with statewide partners. The Office recommends policies, procedures, activities and resource allocations to improve health among the state's underserved and diverse populations, and to eliminate health disparities.

The FHS received technical assistance from the National Center for Cultural Competence for Title V staff at DPH and to MCH community providers over two days in May 2010. MCH Staff will monitor compliance with the terms of the contract that address cultural competency. Technical assistance will be provided or procured when needed.

The DPH is a participant on the newly formed Commission on Health Equity (Public Act No. 08-171), which mission is to eliminate disparities in health status based on race, ethnicity and linguistic ability, and improve the quality of health for all of the state's residents.

C. Organizational Structure

Governor M. Jodi Rell has been CT's Governor since July 2004. J. Robert Galvin, MD, MPH, MBA, DPH Commissioner since December 2003, serves as the leading health official in CT and advisor to the Governor on health-related matters. Dr. Galvin brings experience in the fields of medicine and public health, as well a strong commitment to serving the people of CT. DPH is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, certification and training, technical assistance, consultation and specialty services. The mission of the DPH is to protect and improve the health and safety of the people of CT by: assuring the conditions in which people can be healthy; promoting physical and mental health, and preventing disease, injury, and disability.

The Office of Health Care Access merged with the DPH and became a branch within DPH in SFY 2010. As a result, DPH is now comprised of nine Branches. The majority of the Title V activities are located in the Public Health Initiatives (PHI) Branch and a detailed description follows:

The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. The majority of CT's Title V program activities reside within the FHS. Other MCH-related programs such as oral health, childhood lead poisoning prevention, diabetes, tobacco, obesity prevention and asthma are in other sections within the DPH. Other branches within DPH work cooperatively with Title V funded programs and provide support to programs that promote maternal and child health in the state of CT. The Title V Program is responsible for the administration (or the supervision of the administration) of programs carried out with funds from the MCHBG.

CT's 31 birthing facilities send blood specimens collected from all newborns to the Laboratory

Branch for genetic screening. Following specimen analysis, the laboratory staff forwards all abnormal screening results to the Newborn Screening Tracking Program (NBST) for rapid short-term follow-up. NBST is partially funded by the MCHBG.

Block Grant funds support a full time equivalent in the Health Information Systems and Reporting Section, in the Planning Branch to maintain vital record databases containing information on births, deaths, hospitalizations and risk factors related to maternal and child health. Epidemiologists use vital record information to help direct and evaluate Title V program activity.

The Primary Care and Prevention (PCP) Unit promotes health care to the Maternal and Child Health population, including women of childbearing age, pregnant and postpartum women, and their partners and children. Access to care is promoted through support of safety net providers. Contractors provide: (1) case management services for pregnant women and teens (including secondary teen pregnancy prevention and parenting programs) to promote good birth outcomes; (2) comprehensive primary care services through community health centers; (3) family planning; (4) rape prevention education and crisis intervention and the prevention of intimate partner violence; (5) medical and mental health services to children and adolescents in School Based Health Centers (SBHC); and (6) perinatal depression training to health care providers. Programs supported in this unit include 1) Case Management/Parenting Programs, 2) Centering Pregnancy, 3) First Time Motherhood/New Parents Initiative, 4) State Healthy Start, 5) Healthy Choices for Women and Children, 6) Perinatal Depression Training, 7) MCH Information and Referral Service, 8) Intimate Partner Violence Prevention, 9) Rape Prevention Education and Crisis Intervention, 10) Community Health Centers, 11) Family Planning, 12) School Based Health Centers/Expanded School Health, and 13) Waterbury Health Access Program.

This unit provides representation to the federal Office on Women's Health -- Region I, Department of Health and Human Services.

The Registry and Program Support Unit provides data and analytical support to the FHS programs, including the provision of required information for the MCHBG and the Preventive Health and Health Services Block Grant national and state performance measures. This unit also coordinates the State Systems Development Initiative grant (the infrastructure grant related to the MCHBG). The Birth Defects Registry and the CT Immunization Registry and Tracking System (CIRTS) staff are in this unit. CIRTS collaborates with the Immunization Program activities. This unit seeks to identify and collect population-based MCH data, as well as create new data systems to complement existing data that will enhance the section's ability for program planning, evaluation and surveillance.

The Children and Youth with Special Health Care Needs (CYSHCN) Unit includes: 1) the Medical Home Initiative, 2) the Early Hearing, Detection and Intervention (EHDI) Program, 3) Sickle Cell Disease Program, and 4) State Implementation grants for Integrated Community Systems for CYSHCN.

The goal of the Medical Home Program is to build the state infrastructure to: 1) reach more CYSHCN and their families and assist them with access and coordination of multiple systems of care and resources; 2) assist the Pediatric Primary Care Providers (PCPs) to identify CYSHCN with high severity needs who need care coordination; 3) link with regional family support networks; 4) provide respite planning and funding for respite family-based services; 5) provide benefits coordination for families to access durable medical equipment, prescriptive medications and specialized formulas; 6) assist PCPs to identify youth with special health care needs to receive the services necessary to make transitions to all aspects of adult life, and 7) liaison with Child Development Infoline (MCH Information and Referral Services for CYSHCN). The EHDI Program ensures early hearing detection and intervention for infants identified with a hearing loss. The goal of the EHDI program is to assure quality developmental outcomes for infants identified with hearing loss. The Sickle Cell Disease Program provides comprehensive coordination of adults with Sickle Cell Disease (SCD) and Trait by improving adult SCD

healthcare services and improving transition from pediatric to adult SCD healthcare services. The program also provides advocacy for optimal use of state and federal resources.

The Immunizations Unit's main focus is to prevent disease, disability and death from vaccine-preventable diseases, through surveillance, case investigation and related control, and by monitoring immunization levels in infants and children through annual daycare and school surveys, provision of vaccines for all children and selected adults, support to local health departments for immunization coordination and outreach, and conducting professional and public education. Programs include 1) Vaccines for Children Program, 2) Immunization Action Plan, 3) Vaccines for Preventable Diseases Surveillance, and 4) Adult Immunization Program.

The Program Development Unit performs public health surveillance and research on MCH topics, prepares reports and other communications. The unit supports administration of the Title V Block Grant, manages other federally funded grants in the Section, and seeks new funding for evidence-based and theory-driven interventions that address emerging MCH needs. Initiatives include 1) the Pregnancy Risk Assessment Tracking System (PRATS), 2) Early Childhood Comprehensive Systems, 3) Hartford Healthy Start and 4) Primary Care Office.

The Office of Oral Health has been transitioned to the Local Health Administration Branch. A strong collaborative relationship exists with the MCH programs and the Office of Oral Health.

An attachment is included in this section.

D. Other MCH Capacity

The CT Department of Public Health is comprised of nine Branches. The Title V Program is located within the FHS, which is part of the Public Health Initiatives (PHI) Branch. Lisa A. Davis, RN, BSN, MBA, is the Chief of the Public Health Initiatives (PHI) Branch.

Rosa M. Biaggi, MPH, MPA, is the Chief of the Family Health Section (FHS) and the State MCH Title V Director. Ms. Biaggi began working in the FHS in 2009. Janet M. Brancifort, MPH, became the Public Health Services Manager for the FHS in March 2007. (CVs attached).

Administrative support to the Section management is provided by an Administrative Assistant and a Secretary 2.

The Family Health Section employs 54 permanent staff with expertise and skills in various areas of public health and MCH related fields. Most of the professional staff within the Family Health Section have graduate degrees or have experience in nursing, social work, allied health, health education, research, evaluation, epidemiology, law, planning, administration, and management. The majority of CT's Title V program activities reside organizationally within the FHS in the PHI Branch.

Sharon Tarala, RN, JD, Supervising Nurse Consultant, supervises the Primary Care & Prevention (PCP) Unit. and serves as the State Women's Health Coordinator. There are seven staff in the unit: two (2) Nurse Consultants, one (1) Social Work Consultant, two (2) Health Program Assistant 1, one (1) Health Program Assistant 2, and one (1) vacant CT Career Trainee position and is in the process of being filled.

Marcia Cavacas, MS, supervises the Registry and Program Support Unit. There are seven staff in the unit: two (2) are Epidemiologist 2; one (1) Epidemiologist 3, one (1) Health Program Associate, two (2) Health Services Workers, and one (1) Office Assistant.

Mark Keenan, RN, MBA, Supervising Nurse Consultant, serves as the state's Title V CYSHCN Director and leads the CYSHCN Unit. There are seven staff in the unit: one (1) is a nurse consultant, three (3) are Health Program Associates, two (2) Health Program Assistant 1 and one

(1) Secretary 1. One of the Health Program Assistant positions is vacant and is in the process of being filled. One (1) Health Program Associate serves as the agency Family Advocate and is a parent of children with special health care needs. This staff member provides consultation regarding family issues ensuring that a family-centered, culturally competent perspective is maintained.

Vincent Sacco, MS, Epidemiologist 4, supervises the Immunizations Program. There are 20 staff in the unit: three (3) Epidemiologist 3, six (6) Epidemiologist 2, one (1) Health Program Assistant 1, three (3) Clerk Typists, one (1) Health Program Associate, two (2) data entry clerks, one (1) Information Technology Analyst 2, one (1) Materials Storage Handler, one (1) Secretary 2, and one (1) Assistant Program Coordinator.

E. State Agency Coordination

E. State Agency Coordination

CT's Title V Program works with other state agencies and within its own programs to ensure coordination of services. The narrative below describes the most important of those collaborations.

Under the state's Medicaid program, grants are made to hospitals, clinics, departments of health and other organizations to expand and enhance health services to low income pregnant women and children, and to assist women in obtaining Medicaid coverage for themselves and their children. Healthy Start contracts are jointly administered by the DSS and the DPH.

CT Maternal-Child Health Advisory Committee offer a networking opportunity for MCH providers to share relevant information and resources available to the state's MCH populations and coordinate efforts in order to maximize resources and services available to Connecticut's women, children and families. The Committee meets on a quarterly basis.

The CYSHCN program collaborates with the DSS Health Insurance for Uninsured Kids and Youth Unit to promote access to public health insurance for CYSHCN, to align and improve services and programs for CYSHCN. CYSHCN staff serve on the legislatively mandated Medicaid Managed Care Council. CYSHCN program staff network with the Social Security Administration/Disability Determination Unit at DSS to facilitate the referral of enrollees to the program.

DPH CYSHCN program staff participate on: the Birth to Three Interagency Coordinating Council, the CT Council on Developmental Disabilities, the A.J. Pappanikou Center for Excellence on Developmental Disabilities Consumer Advisory Board, and the legislatively mandated Family Support Council. CYSHCN staff facilitate and participate on the DPH Medical Home Advisory Council (MHAC), which provides guidance to DPH on efforts to improve the system of care for CYSHCN. The MHAC membership is comprised of more than 40 representatives, including family representation, providers, contractors involved in the CT Medical Home Initiative for CYSHCN, public and private agencies, and youth with special health care needs. State agencies participating in the MHAC include: DPH, State Department of Education (SDE), DSS, Department of Children and Families (DCF), DDS, Office of Policy and Management (OPM), and Office of the Child Advocate (OCA).

A State Implementation Grant for Integrated Community Systems for CYSHCN activities focusing on transition of youth with special health care needs to adult services has resulted in MOUs with the DCF, the SDE- Bureau of Special Education, and DSS-Bureau of Rehabilitation Services.

The CYSHCN program partners with United Way of CT/2-1-1 Infoline (CT's MCH Information and Referral Service), DDS (Birth to Three), and the Children's Trust Fund (Help Me Grow) in

supporting United Ways's Child Development Infoline (CDI) to serve as the statewide point of entry and referral for all CYSHCN. CDI implements a referral and coordination of services model to assess and refer appropriate CYSHCN to Birth to Three, Ages and Stages, Help Me Grow and CT Medical Home Initiative for CYSHCN resources (including referral to community based medical homes). CYSHCN staff serve on the CDI steering Committee.

The CYSHCN program and the CT Lifespan Respite Coalition, Inc. (CLRC) have partnered to create and disseminate a two-section "Get Creative About Respite" manual.

The CYSHCN program staff work with partners implementing the CT Medical Home Initiative for CYSHCN that includes family and professional partnership and support staff, respite and extended services administration, and community based medical home staff.

The CYSHCN program partners with contractors associated with the CT Medical Home Initiative for CYSHCN to distribute "Directions: Resources for Your Child's Care" an information organizer for families, available in English, Spanish, and Portuguese.

The Early Hearing Detection and Intervention program staff work with the 31 CT birthing facilities, State Laboratory, Audiology Diagnostic Centers, the Regional Treatment Centers and individual medical homes to assure the testing, tracking, and treatment components of the Universal Newborn Hearing Screening and Laboratory Programs.

CYSHCN/EHDI program staff are active members of the CT Early Hearing Detection and Intervention (EHDI) Task Force. The Task Force members include representatives from the DSS, DDS, birth hospital nurse managers, UConn Division of Family Studies, neonatologists and audiologists. The group meets monthly to plan and coordinate activities across state and other agencies, that promote optimal outcomes for infants and children through age 5 identified with hearing loss. The EHDI program has a data sharing MOU in place with DDS Birth to Three to facilitate outreach.

Quarterly meetings are held with a Genetic Advisory Committee (GAC), comprised of the Sickle Cell, Genetics and Metabolic specialty treatment centers and Newborn Screening Program staff from the FHS and DPH State Laboratory, as well as a consumer representative from the Citizens for Quality Sickle Cell Care, Inc.

The CT Expert Genomics Advisory Panel advises the Commissioner on the development of a Genomics Statewide Plan. This committee is comprised of representatives with expertise in genetics, law and bioethics; individuals from industry, insurance and academia; medical providers, genetic counselors; and consumer advocates.

Family Health Section staff participates in the Sickle Cell Consortium, working to implement the statewide sickle cell plan. The consortium is comprised of advocacy groups, sickle cell associations, hospitals, treatment centers, and providers. The plan has been widely disseminated to nine other states and the National Sickle Cell Disease Association. The consortium is finalizing an emergency department protocol for the management of Sickle Cell crisis to be implemented statewide.

Health professionals of the DPH Newborn Screening Program and the Regional Treatment Centers participate on various state, regional, and national committees and resource groups such as: the CT PKU Planning Group, NE Mothers Resource Group, New England Consortium of Metabolic Programs, NERGG, Inc., National Newborn Screening Genetic Resource Center, and the National Newborn Screening Advisory Committee. Participation on these committees provides the opportunity to network with experts and consumers, participate in educational conferences, and keep abreast of advances in genetics and newborn screening as they impact public health. Program staff participates in the UConn MPH Program and provide NBS educational sessions to students as part of the Genetics course curriculum.

CT SBHC have formed a non-profit independent organization, the CT Association of SBHC, Inc., to advocate for this service delivery model. The epidemiologist supporting the SBHC program convenes conference calls with a Data Steering Committee that identifies technical, data quality and other issues that need resolution. The committee members are peer mentors for other sites requiring assistance.

Seventy-five SBHC in 23 communities are partially funded by DPH serving students in elementary, middle and high schools. SBHC are licensed as outpatient facilities and staffed by both a licensed primary care provider and licensed mental health clinician. They offer an array of services addressing the medical, mental and oral health needs of youth, including crisis intervention, health education, social services, outreach, and substance abuse prevention services. The practitioners coordinate the care they provide with a child's primary providers and/or specialists, while integrating the needs of the child with other school personnel. There are 10 Expanded School Health Service programs in three communities, which vary by site and do not provide the full compliment of services provided through traditional SBHC. Services are available to all enrolled students in the school. All expanded school health services programs are currently providing mental health services. Eight offer oral health care.

A SBHC Ad Hoc Committee was formed with the goal of improving health care through access to SBHC, particularly by under- or uninsured people or Medicaid recipients.

Community Health Centers (CHC) provide comprehensive primary and preventive health care and other essential public health services at over 150 sites in CT. DPH funds 13 of the 14 community health center corporations in CT, and 12 of the 13 are members of the Community Health Center Association of CT (CHCACT). All centers are located in HPSA and/or Medically Underserved Areas and operate in accordance with Federally Qualified Health Center Guidelines. In FY09, 242,034 people were served with a wide variety of comprehensive services, including EPSDT. The CHC also work with Family Planning, WIC, SBHC, Infoline and many community-based organizations that provide other health care and social services.

DPH and CHCACT work together on a number of important initiatives to promote, inform policy, and develop community based systems of care for the state's most vulnerable populations and to support CHC. Among these are National Health Service Corps recruitment and retention activities and immunization program initiatives.

The statewide family planning program is implemented through a contract with Planned Parenthood of Southern New England (formerly Planned Parenthood of CT, Inc.) in 16 sites. The services provided include comprehensive preventive and primary reproductive health care for adolescents and adults. During FY 2009, 35,015 clients received services; of those, 32,210 were women, 7,593 were teens, 17,630 were women and men of color, and 26,171 were low-income. The program goals and activities include education in a variety of forums for youth, parents, teachers, social workers and clergy. Forums are held in schools, churches, community-based social service offices and recreational programs. The prevention focus includes the prevention of pregnancy, sexually transmitted infections, Hepatitis and HIV/AIDS.

The DPH participates on the CT Breastfeeding Coalition (CBC), which includes representatives from the state and local WIC program, La Leche League, AAP, Hospitals, CHC, Health Management Organizations (HMO), Universities, independent Lactation Consultants, Medela Corporation and consumers. The Coalition meets on a monthly basis and has 4 active committees: Policy and Advocacy, Data, Provider Education, and Public Awareness. The goals of CBC are to increase public awareness and support for breastfeeding statewide and promote breastfeeding as the social norm. The FHS continues to work closely with the WIC program to promote and support breastfeeding in the state. The CBC includes representatives from breast pump manufacturers, and provides information and input on breastfeeding in the legislative arena.

As part of the Women's Health Initiative, DPH staff actively participates in the Office of Women's Health Region 1 Workgroup to increase the focus on women's health, foster collaboration, and encourage the development of women's health activities in the state and in the New England region.

During National Women's Health week, DPH collaborated with the CT Sexual Assault Crisis Services (Connsacs) and other DPH initiatives to raise awareness about sexual assault prevention, nutrition, cardiovascular disease and HIV/AIDS. Community based forums that addressed these topics were conducted in New Haven, Bridgeport, Hartford and at a shopping mall.

The SBHC staff participate participates in Regional Adolescent Health Coordinators monthly conference calls.

The MOU between DPH and DSS regarding data exchange exists to improve public health service delivery outcomes for low-income populations through the sharing of available Medicaid, HUSKY Part B and Plus, and Title V data. The initial MOU addresses the linkage of birth and Medicaid data, childhood lead screening and Medicaid data, and data on Children Receiving Title V Services and Medicaid data. The DPH-DSS MOU was amended to include the Department of Children and Families (DCF.

DPH worked the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-CT) initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the HCC-CT leadership team. HCC-CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus. As part of the HCC-CT initiative, DPH contracted with the CT Nurses Association (CNA) to conduct child care health consultant workshops for day care health consultants, education consultants and directors of day care facilities, and will coordinate with DSS and CNA to offer medication administration training. DPH will allow HCC-CT access to its learning management site, CT TRAIN, to facilitate workshop enrollment and track participant's CEUs.

The DPH-Local Health Administration Branch, assists and advises local health districts in the state in planning, providing, and advocating for public health services on the local level. The services provided include prenatal and family planning clinics, child health clinics, nutrition services, immunizations, communicable disease surveillance and control, HIV counseling and testing and other services. DPH's Local Health Branch administers state funding for local health departments and districts.

The Early Childhood Partners (ECP) Initiative, funded through the Early Childhood Comprehensive Systems grant, works to develop a comprehensive statewide system to support all CT families so their children attain optimum health and school readiness by age five. Staff serve on the Fatherhood Initiative, facilitated by DSS, and as alternate to the DPH Deputy Commissioner on the State Early Childhood Advisory Council.

To address intentional and unintentional injuries, the DPH Injury Prevention Program (DPH-IP) collaborates with the CT Department Of Transportation (DOT), SDE, DCF, DSS, OCA, Court Support Services Division (CSSD), and other public, private, and community-based organizations. State and local SAFE KIDS Coalitions (membership includes health care, EMS, Police, Fire and community service providers) address motor vehicle injuries. DPH-IP facilitates the CT Young Worker Safety Team, a collaboration that includes the CT and US Departments of Labor and the CT SDE. The group promotes awareness and training to decrease adolescent work related injuries. DPH-IP facilitates the Interagency Suicide Prevention Network, an interagency, interdisciplinary collaboration that has completed a statewide, comprehensive

suicide plan and works with collaborators to address intentional injury issues including suicide prevention, violence prevention, domestic/dating violence prevention and child maltreatment. DPH-IP participates in the Northeast Injury Prevention Network, which includes State Health Injury Prevention Programs from Regions I and II, university-based injury research centers and representatives from federal regional offices. The Network collaborates on injury prevention initiatives of relevance to both the region and the individual states. DPH-IP is also collaborating with MCH and the Connecticut Office of Rural Health on a rural injury initiative focused on motor vehicle and self-inflicted injury.

The Immunization's staff facilitates the Vaccine Purchase Advisory Committee (VPAC) that makes recommendations to the State Department of Public Health on issues related to the use of publicly purchased vaccines for childhood and adolescent vaccinations. Membership of committee includes the AAP, CHCACT, CT Association of Public Health Nurses, and CT Association of School Nurses. The committee also includes representatives of the vaccine manufacturers, medical directors, and medical insurers. The VPAC is open to the public.

F. Health Systems Capacity Indicators

Introduction

The state of Connecticut has experienced an overall increase in the use of health services for children, as well prenatal care. Recent changes within the HUSKY plan, such as an increase in the eligibility limit for HUSKY A to 250% of the federal poverty level, and initiation of presumptive eligibility and expedited enrollment among pregnant women may further positively impact these measures.

Activities conducted by the Office of Oral Public Health may have contributed to the increased percent of dental visits observed among children aged 6-9 years. More work is needed to address the disparities in services accessed by Medicaid enrollees.

Efforts continue within DPH to link birth data to other data in the state. Discussions are pending with DSS to share enrollment data of women early in pregnancy, and to link these records to subsequent fetal deaths and live births. This would allow population-based information about a variety of health plans managed by DSS, including enrollment figures for Medicaid, HUSKY A, SCHIP, Fee-for-Service, and the new Charter Oak plan. Renewed MOAs with DSS by the Immunization and Lead Screening programs will allow Medicaid enrollment records to be linked to these databases.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	32.0	39.5	37.3	33.8	35.0
Numerator	676	802	788	715	737
Denominator	211036	202831	210985	211637	210470
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: CY 2009 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2009 hospital discharge data and denominator is 2009 population estimates, provided by K. Backus- Table 1 of the Registration Report.

Notes - 2008
Source: CY 2008 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2008 hospital discharge data and denominator is 2008 population estimates, provided by K. Backus- Table 1 of the Registration Report.

Notes - 2007
Source: CY 2007 in-patient hospitalization data provided by J.Morin, FHS, PHI Branch. Numerator is 2007 hospital discharge data and denominator is 2007 population estimates, provided by F. Amadeo - Table 1 of the Registration Report.

Narrative:
The rate of children less than five years of age hospitalized for asthma fluctuated in 2005 and 2006 between 32.0 and 39.5 per 10,000 children, and since then has remained at 37.3 per 10,000 children. DPH is awaiting receipt of 2008 and 2009 hospitalization data to update this measure. A slight increase in this rate is possible.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.9	86.2	86.6	94.2	86.5
Numerator	14386	14429	15133	16833	15542
Denominator	16369	16739	17475	17866	17961
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: CT Dept of Social Services, 2009 CMS 416 report.

Notes - 2008
Source: CT Dept of Social Services, 2008 CMS 416.

Notes - 2007
Source: CT Dept of Social Services, 2007 CMS 416.

Narrative:
The percent of Medicaid enrollees whose age is less than one year during the reporting year and who received at least one initial periodic screen has fluctuated since 2005, with a low of 86.2% in 2006 and a high of 94.2% in 2008. A slight increasing trend in this percentage may have occurred.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.0	73.7	82.0	83.9	83.9
Numerator	482	365	445	366	366
Denominator	595	495	543	436	436
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CT Dept. of Social Services was not able to report on this measure for 2009 due to the HUSKY participation report no longer being available. SFY2008 data used.

Notes - 2008
Source: CT Dept of Social Services, SFY2008 HUSKY participation report (This represents data from 2 MCOs that were part of the SCHIP program).

Notes - 2007
Source: CT Dept of Social Services, SFY2007 HUSKY participation report.

Narrative:
The percent of SCHIP enrollees whose age is less than one year and who received at least one periodic screen varied from a low of 73.7% in 2006 to a high of 83.9% in 2008 and 2009. A slight increasing trend may have occurred.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	80.2	80.2	79.1	79.0	79.0
Numerator	32773	32809	32152	31291	31291
Denominator	40885	40898	40659	39622	39622
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Source: CY2009 Vital Statistice data not available. CT Dept of Public Health, Final 2008, Vital Statistics.

Notes - 2008
Source: CT Dept of Public Health, Final 2008, Vital Statistics.

Notes - 2007
Source: CT Dept of Public Health, Final 2007, Vital Statistics.

Narrative:
In 2009, 79.0% of women 15 through 44 years old with a live birth during the reporting year received an observed-to-expected ratio of prenatal visits that was greater than or equal to 80% of the Kotelchuck Index. No trend is apparent with the data. It is possible that implementation of recent interventions in the state, such as presumptive eligibility and expedited enrollment for HUSKY, may positively impact this measure.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	47.9	48.8	52.2	54.9	52.5
Numerator	129346	137566	145359	156715	157840
Denominator	269941	281910	278677	285538	300731
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: CT Dept. of Social Services, 2009 CMS 416 report, representing the percentage of children under 21 who received a well child visit during the noted Fiscal year.

Notes - 2008
Source: CT Department of Social Services, 2008 CMS 416

Notes - 2007
Source: CT Department of Social Services, 2007 CMS 416

Narrative:
The percent of potentially Medicaid-eligible children who received a service paid by the Medicaid program increased from a low of 47.9% in 2005 to a high of 54.9% in 2008. This continued increase is a positive since DSS has had changes in the number of MCOs participating in the program, and has also introduced the Charter Oak health insurance plan for all state residents.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	43.7	48.1	53.0	52.3	52.1
Numerator	24689	26848	29007	29283	30567
Denominator	56549	55848	54775	55971	58683
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: CT Dept. of Social Services, FFY2009.

Notes - 2008
Source: CT Dept of Social Services, FFY2008.

Notes - 2007
Source: CT Dept of Social Services, 2007 CMS 416.

Narrative:
After an initial increase in the percent of EPSDT-eligible children aged 6 through 9 years who received a dental service during the year (43.7% in 2005 to 53.0% in 2007), the percentage decreased slightly to 52.1% in 2009. Efforts to encourage pediatric oral health services will continue.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.6	4.3	8.8	8.8	9.6
Numerator	47	259	546	546	624
Denominator	1296	6008	6230	6230	6475
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: 2009 data are from the CYSHCN Access database that includes information from active Medical Homes. A total of 6782 CYSHCN received services from the program. An estimated 9.2% of these receive SSI of 624 for the numerator. The denominator is the actual number of CT residents <16 receiving SSI 6475.

Notes - 2008
Source: CY2008 data not available.
Source of 2007 data are from the CYSHCN Access database that includes information from active Medical Homes. A total of 5931 CYSHCN recieved services from the program. An

estimated 9.2% of these receive SSI of 546 for the numerator. The denominator is the actual number of CT residents <16 receiving SSI 6230. This data source is different than that used in 2006, but the CYSHCN Program feels that the 2007 figures are a more accurate method of calculating the percent of SSI beneficiaries receiving rehabilitative services.

Notes - 2007
Source: A total of 5931 CYSHCN recieved services from the program. An estimated 9.2% of these receive SSI of 546 for the numerator. The denominator is the actual number of CT residents <16 receiving SSI 6230. This data source is different than that used in 2006, but the CYSHCN Program feels that the 2007 figures are a more accurate method of calculating the percent of SSI beneficiaries receiving rehabilitative services.

Narrative:
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with special Health Care Needs (CSHCN) Program has seen a dramatic increase from 3.6% in 2005 to 9.6% in 2009. This dramatic change may be due to the change in the data source used in 2009.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	9.2	7.4	8.9

Notes - 2011
Source: CT DPH Vital Statistics Final 2007 matching births to Medicaid eligibility information. CY 2008 data are not available.

Narrative:
The most recent linked birth-Medicaid data file available is for the CY 2007 birth cohort. The percent of low birth weight babies was 1.2 times higher among Medicaid births (9.2%) than among non-Medicaid births (7.4%). DPH continues to collaborate with the Department of Social Services, which administers the State's Medicaid program. DPH provides MCHBG funding for the state Healthy Start program, which provides case management and home visitation services to pregnant Medicaid-eligible women and their children up to age three. A recently developed strategic plan to address low birth weight in the state may also help address this disparity.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

Infant deaths per 1,000 live births	2007	matching data files	8.8	5.4	6.6

Notes - 2011
Source: CT DPH Vital Statistics Final 2007 matching births to Medicaid eligibility information. CY 2008 data are not available.

Narrative:
The percent of infant deaths is 1.6-times higher among births to Medicaid enrollees.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	75.9	92.6	86.4

Notes - 2011
Source: CT DPH Vital Statistics Final 2007 matching births to Medicaid eligibility information. CY 2008 data are not available.

Narrative:
The percent of infants born to women who received early prenatal care was 1.2-times better among non-Medicaid enrollees (92.6%) than among Medicaid enrollees (75.9%). The FHS represents DPH on the Women's Health Subcommittee of the Medicaid Managed Care Council and will continue to explore ways to encourage entry into prenatal care.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	69.9	82	77.5

Notes - 2011

Source: CT DPH Vital Statistics Final 2007 matching births to Medicaid eligibility information. CY 2008 data are not available.

Narrative:
The percent of pregnant women with adequate prenatal care was 1.2-times better among non-Medicaid enrollees (82.0%) than among Medicaid enrollees (69.9%). The FHS represents DPH on the Quality Assurance Subcommittee of the state's Medicaid Managed Care Council and will continue to explore ways to increase the quality of prenatal care for women enrolled in Medicaid. Also, initiation of the Primary Care Case Management program within the HUSKY system may help address this disparity in the future.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Notes - 2011
Source: CT Dept. of Social Services.

Notes - 2011
Source: CT Dept. of Social Services.

Narrative:
Eligibility for HUSKY A increased in January, 2009 from 185% to 250% of the federal poverty level. This will allow more low-income women access to prenatal care services. In addition, expedited and presumptive enrollment in HUSKY A for pregnant women was also recently implemented within DSS. These changes may positively impact prenatal care services.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 22) (Age range to) (Age range to)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19)	2009	300

(Age range to) (Age range to)		

Notes - 2011
Source: CT Dept. of Social Services.

Notes - 2011
Source: CT Dept. of Social Services.

Narrative:
There has been no change in eligibility for the state's SCHIP program. Eligibility remains at 300% of the federal poverty level.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	250
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	250

Notes - 2011
Source: CT Dept. of Social Services.

Notes - 2011
Source: According to Dept. of Social Services pregnant women are not covered under SCHIP.

Narrative:
There has been no change in eligibility in the Medicaid and SCHIP programs. Eligibility remains at 250% of the federal poverty level.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
	2	Yes

Annual linkage of birth certificates and WIC eligibility files		
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	Yes

Notes - 2011

Narrative:
This measure remained unchanged. FHS personnel continue to pursue regular access to WIC eligibility files that will allow linkage to birth records. Connecticut's third PRATS survey is scheduled to begin in Summer 2010.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:
The most recent Connecticut School Health Survey (YRBS) was conducted (2009), and the report findings were just released.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Connecticut (CT) Department of Public Health (DPH), Family Health Section (FHS) utilized the framework included in the Title V Application Guidance (engaging stakeholders, assessing needs and identifying desired outcomes and mandates, examining strengths and capacity, selecting priorities, seeking resources, establishing performance objectives, developing an action plan, allocation of resources, monitoring impact on outcomes, and reporting back to stakeholders) to ensure all steps in the needs assessment were addressed to identify needs for 1) preventive and primary care services for pregnant women, mothers and infants up to age one; 2) preventive and primary care services for children; and 3) services for Children with Special Health Care Needs (CSHCN) from October 2008 -- May 2010. The MCH needs assessment was designed to be population-based, community focused, and framed within a family context.

The MCH Title V Program established an MCH Needs Assessment Planning Committee to assist in the oversight and direction of the needs assessment. The Planning Committee included staff from the various MCH programs.

The Planning Committee determined that the needs assessment process would include a DPH Internal Needs Assessment, a Community Centered Needs Assessment, and a Stakeholders Committee that would assist with selecting State priority areas.

Each Internal Needs Assessment workgroup was instructed to recommend up to 5 priority needs for a total of 15 priority needs to be considered by the Stakeholders Committee. In the Community Centered Needs Assessment, both qualitative and quantitative methods were used to inform the comprehensive needs assessment process. Additional feedback on the health needs of women and children was obtained from providers and consumers. Engaging the various stakeholder groups facilitated the inclusion of their insights and experience of their practical experiences and served as a valuable reality check. A concerted effort was made to engage providers, advocates and consumers in both identifying priority needs and successful solutions to identified problems.

The Stakeholders Committee met in May 2010, to review the identified priority needs from the Internal and Community Centered Needs assessments and to select 7-10 priority areas to improve maternal and child health. The Stakeholders Committee selected 9 priority areas.

DPH established state performance measures for each priority area.

B. State Priorities

Through the Needs Assessment process completed for the 2011 Application, DPH identified nine State priority needs.

1. Enhance Data System

The goal is to increase the number of core databases integrated into the Health Informatics Profile for CT Kids (HIP-Kids), a data warehouse containing a comprehensive child health profile created by linking disparate databases into a single comprehensive system. There is no National Performance Measure that addresses this need and the rationale for creating a State Performance Measure.

Insufficient data and research are available to adequately support MCH program development and the evaluation of existing programs, especially in terms of obtaining new funding and reporting the appropriate information for existing grants and initiatives. Databases containing child

health information are housed in different areas of the agency. These data are currently not linked, and they are analyzed in isolation of one another, thus limiting essential public health functions. The Health Informatics Profile for CT Kids (HIP-Kids), a data system of linked child health information at the record level, is currently under development to address this problem. The seven (7) core datasets identified for inclusion in HIP-Kids are not yet integrated completely. The fully developed HIP-Kids data warehouse will support the agency's public health assurance, assessment and evaluation activities; interdivisional public health research activities and initiatives, and inform public health policy.

2. Improve Mental/Behavioral Health Services

Annually, about one out of every five CT children has a mental health or substance abuse problem. Fewer than half get any treatment. In 2008-2009, mental health as a primary diagnoses accounted for more than one third (37%) of all SBHC clinic visits. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in mental health services provided to adolescents. The proxy measure is intended to monitor the SBHC students that visited a SBHC clinic that received a risk assessment with a Mental Health component who come in for intake physical exams or children referred by parents, teachers, etc.

3. Enhance Oral Health Services

Dental caries is the single most common chronic childhood disease, 5 times more common than asthma and 7 times more common than hay fever. Prolonged lack of treatment can lead to tooth loss, systemic infection, and the entry of toxins and by products of inflammation into the bloodstream. Dental disease in a young child can affect their development, school readiness, and attendance. While National Performance Measure #09 addresses children receiving dental sealants, there was a strong consensus that more preventive activities needed to be monitored.

This resulted in the goal to reduce the prevalence of dental caries through increased recognition of the importance of early dental caries prevention prior to tooth eruption, dental visits beginning at age one, fluoride varnish applications (where appropriate) and the importance of optimal oral health for the mother. A new State Performance Measure was created to expand on monitoring prevention activities completed by dental care providers.

4. Reduce Obesity among the three target MCH populations

The association between the consumption of fruits and vegetables and preventing or reducing obesity prevalence has been established. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to attempt to measure improvement in reducing obesity among the three target MCH populations. Offering fruit and vegetables vouchers to WIC participants works as incentives for participants to purchase more fresh fruits and vegetables. With increased availability and access to fresh fruits and vegetables, it is hoped that the participants would change their dietary habits and increase their consumption of fruits and vegetables. By increasing the consumption of fruits and vegetables, participants would be in a better position to combat obesity or prevent becoming obese.

5. Enhance Early Identification of Developmental Delays, Including Autism

The five National Performance Measures addressing the needs of the CYSHCN population do not directly address this aspect of the life of a CYSHCN. The 2005/2006 National Survey of CSHCN revealed that 3.8% of Connecticut's CSHCN population, or roughly 5,057 children were diagnosed with Autism Spectrum Disorder (ASD). Early identification is a component of meeting the needs of CYSHCN, including those with ASD, and the focus will be on the 0-3 population and provider education. A State Performance Measure was created to increase awareness and recognition of the importance of early identification of developmental delays on the part of

providers as evidenced by an increase in the percentage of 0 to 3 year olds receiving a developmental screening within the last twelve months; thereby facilitating subsequent evaluation and referral to services.

6. Improve the Health Status of Women, including depression

A woman's health across the lifespan includes her reproductive years, as well as pre-reproductive and post-reproductive years. Use of a culturally-sensitive and evidence-based preconception screening tool can address many risk factors (including depression) for pregnancy and birth complications before a woman becomes pregnant, and needs to be encouraged as a best-practice protocol among professional service providers who serve women. There is no National Performance Measure that addresses this need and the rationale for creating a proxy State Performance Measure to measure the number of DPH funded Case Management programs whose healthcare professionals complete preconception health screening (including depression) of women.

7. Improve Linkages to Services/Access to Care

There is no National Performance Measure that addresses this need. DPH's PCO works to identify medically underserved areas in CT that may qualify for a federal designation as Medically Underserved Area or Population or Health Professional Shortage Area as underserved areas for primary care, dental or mental health care. Identifying needy areas in the state and then obtaining a federal designation are the first steps toward getting the necessary resources to improve health care services and access in local communities. A State Performance Measure was created using the information available from the PCO to promote and provide access to health care programs and services especially among the underserved populations by increasing the number of Health Professional Shortage Area (HPSA) designations in the State.

8. Integrate the Life Course Theory throughout all state priorities

There is no National Performance Measure that addresses this need. The general concept of life course theory is to address early childhood determinants of adult health, before health conditions are realized in adulthood. Interventions are needed in childhood that decrease the risk factors of poor health in adulthood and that maximize protective factors. A paradigm shift is needed to focus public health initiatives on children, with the intention of curbing poor health in adulthood. A State Performance Measure was created to monitor the extent to which DPH has incorporated public health interventions that address early childhood determinants of adult health into programmatic action plans.

9. Reduce Health Disparities within the three MCH target populations

There is no National Performance Measure that addresses this need. Improvements in the quality of data collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities. The goal is to increase the availability of racial/ethnic data in the context of the other eight State Priority needs based on Federal and State data collection standards. With adequate resources and attention, a number of documented gaps in health status can be narrowed. Improvements in the quality of data The 2009 Connecticut Health Disparities Report (Stratton, Alison, Margaret M. Hynes, and Ava N. Nepaul. 2009, Connecticut Department of Public Health.), collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	56	60	55	77	68
Denominator	56	60	55	77	68
Data Source				CT DPH Newborn Screening Program	CT DPH Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Source: CY2009 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2008
Source: CY2008 CT DPH Newborn Screening Program supplied the percentage of confirmed cases that also received appropriate follow-up. (For more information on CT's newborn screening procedures/data, see also the detailed note with Form # 6)

Notes - 2007
Source: CY2007 CT DPH Newborn Screening program supplied the percentage of confirmed cases who also received appropriate follow-up. (For more info on CT's newborn screening procedures/data see also the detailed note with Form 6).

a. Last Year's Accomplishments
CT met this objective by ensuring that 100% of infants screened as positive with conditions received follow-up to definitive diagnosis and comprehensive treatment services. Of the 39,481 occurrent births in CT for 2009, 98.8% received newborn screening (NBS) prior to discharge or within the first week of life. A total of 2,100 suspect positive results were reported to state regional treatment centers and/or primary care providers (PCPs) for further testing and follow-up, with 68 diseases and 38 carriers confirmed, and 874 hemoglobin traits identified.

CT implemented universal screening for Cystic Fibrosis (CF) performed at Yale University School of Medicine and the University of Connecticut Health Center (UCHC). Prior to this date, approximately 70% of newborns in 23 of the 31 birthing centers were voluntarily screened for CF. Staff are developing a process to collect CF statistics for national reporting.

There were 710 newborns that had unsatisfactory NBS specimens; all but three were resolved with receipt of a satisfactory repeat specimen. There were eleven CT State waivers submitted to the lab for refusal of screening due to conflicts with religious tenets. Of these, four newborns had specimens later obtained by their PCP.

In November 2008, the Newborn Screening Tracking (NBST) Program instituted the Missing Scan Report (MSR) internal system to track specimens delivered from birthing facilities to the DPH Laboratory. In 2009, there were a total of 839 missed scan specimens. Of these, over 130 specimens needed tracking and follow-up.

State regional treatment center specialists provide NBS education through grand rounds conferences at birthing hospitals and medical schools. Through federal funds, one center provided an interim emergency supply of metabolic formulas for newborns identified with metabolic disorders. Treatment centers continue to receive State level financial support for confirmation testing, follow-up and treatment services, development of treatment plans, genetic counseling, nutritional management, and educational support to patients and families.

With funding support from the MCHBG, the UCHC Genetics Program continues to provide the Pregnancy Exposure Information Services (PEIS) toll-free telephone line. Referrals are made to UCHC Genetics for follow-up. During 2009, this line provided information to 841 pregnant women who were concerned about exposure to toxic substances during pregnancy and the possible effect(s) to their baby.

Three nurse consultants provided 15 technical assistance (TA) opportunities to birthing facilities to assess: 1) the NBS process of data entry at the birth of the baby and 2) collection of specimens through receipt of the laboratory report. DPH also provided statistical reports: the 2008 revised NBS Guidelines, and the Clinical and Laboratory Standards Institute (CLSI) Newborn Screening Collection procedures to facilities for their staff competency programs.

A symposium, "Newborn Screening in the 21st Century", was provided on September 24, 2009 for hospitals and maternal and child healthcare providers. Sessions included: Successes & Dilemmas in NBS, Neonatal Universal Screening for Cystic Fibrosis, the Birth-To-Three Program, Integrating Data Systems, Early Hearing Detection and Intervention, and a Laboratory NBS and Tracking Program panel discussion.

NBS staff met quarterly with the Genetics Advisory Committee to discuss restructuring the committee, Laboratory protocols, confirmed disorders, consumer concerns, and proposed NBS legislative bills. Newborn Screening Laboratory and Tracking staff met quarterly to discuss data systems challenges, quality assurance and statistical reporting. Case and protocol reviews were conducted with Lab staff, hospital nurse managers and treatment center specialists to foster timely and accurate reporting, and to decrease false positive results.

One NBST nurse consultant participated on the DPH Genomics Office's, Council of Genomics, and the Expert Genetic Advisory Panel (EGAP), New England Consortium of Metabolic Disorders, and the New England Regional Genetics Group, Board of Directors and their Public Health Genomics Committee.

The NBST program supervisor participated as an advisory committee member on the New England Genetics Collaborative. Work included collaborations with public health stakeholders to develop regional innovative grants and programs that promote the health and social well being of those with inherited conditions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Participate in the quarterly Genetics Advisory Committee(GAC) meetings.				X
2. Work with other groups to provide education on Genetics and NBS.		X		
3. Screen all infants for selected metabolic or genetic disorders.			X	
4. Refer newborns with abnormal screening results for appropriate services.			X	
5. Development of treatment center services on the expanded NBS panel.				X
6. Update educational programs to reflect the expansion of the NBS testing panel.				X
7. Participate in various State, Regional, and National conferences.				X
8. Support families identified with genetic and metabolic disorders.		X		
9. Enhancing data collection technology for electronic reporting.				X
10. Quality Assurance Measures to track blood specimens.				X

b. Current Activities

DPH NBST continues to ensure early identification of infants at increased risk for over 40 selected metabolic or genetic disorders. DPH NBST continues to: (1) train new staff; (2) develop a process to collect CF statistics from Yale University School of Medicine and the UCHC for national reporting; (3) review Clinical and Laboratory Standards Institute's Newborn Screening for Preterm, Low Birth Weight, and Sick Newborns; (4) prepare for the implementation of guidelines with birthing facilities and their NICUs; (5) work with the treatment centers and their contractual agreements; (6) continue to meet with Laboratory Information Management System (LIMS) and Maven Consultants to move forward the development and intersection of the web-based reporting system with the LIMS; (7) provide TA sessions and telephone assistance to birthing facilities to provide education and ensure timely and accurate collection of NBS specimens and compliance standards; (8) participate in the GAC quarterly meetings to obtain advisement on follow-up protocols, confirm disease results, revise protocols, and address emerging issues; (9) assist in exploring opportunities to expand NBS to include Severe Combined Immunodeficiency (SCID) screening; (10) work to eventually have the Missing Scan Report part of the new Maven system for birthing facility review and (11) continue to collaborate with and participate in regional forums.

c. Plan for the Coming Year

DPH NBST will continue to ensure that all newborns are screened in a timely manner for early identification of infants at increased risk of selected metabolic or genetic diseases. This will allow prompt initiation of medical treatment to avert complications and prevent irreversible problems or death. All newborns with suspect positive results will be referred to state Regional Treatment Centers for confirmation testing, treatment & follow-up, and genetic and nutritional counseling & education.

NBST will: (1) develop a process to collect universal screening CF statistics from Yale University School of Medicine and the UCHC for national reporting; (2) continue to monitor and collect data on unsatisfactory NBS specimens, refusal waivers, and missing scan reports from the birthing facilities; (3) continue to meet with the Laboratory Information Management System Coordinator and the Maven Consultant to proceed forward with the development and implementation of the web-based reporting system; (4) monitor, through quarterly reports and contractual agreements with state regional treatment centers, activities on NBS education through grand rounds conferences at birthing hospitals and medical schools, the Pregnancy Exposure Information Services (hotline for pregnant women), daily patient referrals, and comprehensive treatment services for patients and their families.

NBST nurse consultants will provide technical assistance to selected birthing facilities to assess the NBS process from data entry at the birth of the baby through collection of the specimen and receipt of the laboratory report. Specifically, the Nurse Consultants will educate the birthing facility Neonatal Intensive Care Unit nurse managers on the "Newborn Screening for Preterm, Low Birth Weight, and Sick Newborns; Approved Guidelines," and what is feasible for implementation during this year.

NBST staff will meet quarterly with the Genetics Advisory Committee to discuss restructuring the committee, current and emerging issues related to Laboratory NBS, protocols, confirmed disorders, consumer concerns, and proposed NBS legislative bills. Newborn Screening Laboratory and Tracking staff will meet quarterly to discuss data systems challenges, quality assurance, statistical reporting, and emerging genetic issues. Case and protocol reviews will be conducted with appropriate staff (Lab staff, hospital nurse managers and treatment center specialists) to foster timely and accurate reporting and to decrease false positive results.

One NBST nurse consultant will participate on the DPH Genomics Office's Council of Genomics and Expert Genetic Advisory Panel, and regional committees and advisory groups.

The NBST program supervisor will remain an advisory committee member on the New England Genetics Collaborative to develop regional innovative grants and programs that promote the health and social well being of those with inherited conditions through collaborations with public health stakeholders.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**39481**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	39589	100.3	36	1	1	100.0
Congenital Hypothyroidism (Classical)	39589	100.3	197	12	12	100.0
Galactosemia (Classical)	39589	100.3	232	0	0	
Sickle Cell Disease	39589	100.3	38	21	21	100.0
Biotinidase Deficiency	39589	100.3	76	9	9	100.0
Congenital Adrenal Hyperplasia	39589	100.3	154	1	1	100.0
Hemoglobin Traits	39589	100.3	874	0	0	

Hemoglobinopathies	39589	100.3	38	6	6	100.0
Maple Syrup Urine Disease	39589	100.3	25	0	0	
Tyrosinemia	39589	100.3	17	1	1	100.0
Methylmalonic Acidemia (MMA)	39589	100.3	42	0	0	
Propionic Acidemia (PPA)	39589	100.3	42	0	0	
Isovaleric Acidemia (IVA)	39589	100.3	41	0	0	
Carnitine transporter defect	39589	100.3	9	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	39589	100.3	9	0	0	
Glutaric Acidemia I (GA I)	39589	100.3	26	0	0	
Cirtullinemia or Argininosuccinic Acid Synthetase Deficiency (ASD)	39589	100.3	10	2	1	50.0
Multiple acyl-CoA Dehydrogenase Deficiency (MADD)	39589	100.3	42	0	0	
Hyperammonemia-Hyperornithinemia-Homocitrullinemia Syndrome (HHH)	39589	100.3	7	0	0	
Argininemia (Arg)	39589	100.3	8	0	0	
Homocystinuria Hypermethionema	39589	100.3	19	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency (MCADD)	39589	100.3	25	2	2	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency (VLCADD)	39589	100.3	23	1	1	100.0
Carnitine/Acylcarnitine Translocase Deficiency (CACT)	39589	100.3	21	0	0	
Carnitine Palmitoly Transferance I (CPT I)	39589	100.3	18	0	0	
Carnitine Palmitoly Transferance II (CPT II)	39589	100.3	21	0	0	
Glutaric Acidemia Type II (GA II)	39589	100.3	42	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency (3MMC)	39589	100.3	5	0	0	
3-Hydroxy 3-Methylglutaryl-CoA Lyase Deficiency (HMG)	39589	100.3	5	0	0	
Multiple CoA Carboxylase Deficiency	39589	100.3	5	0	0	

(MCD)						
Nonketotic Hyperglyciemia (NKH)	39589	100.3	7	0	0	
Omithine Transcarbarnylase Deficiency (OTC)	39589	100.3	32	0	0	
Short Chain ACYL-CoA Dehydrogenase Deficiency (SCADD)	39589	100.3	2	1	1	100.0
Argininosuccinic aciduria (ASA)/Argininosuccinase Lyase (ALD)	39589	100.3	10	0	0	
2, 4, Dienoyl CoA Reductase Deficiancy (DCR)	39589	100.3	1	0	0	
Malonic Aciduria	39589	100.3	1	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8
Annual Indicator	59.8	59.8	57.8	57.8	57.8
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	59.8	59.8	59.8	59.8	59.8

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Source: The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments
This measure was not met as there was a 2% decrease from the 2001 SLAITS survey (57.8% in the 2005-06 SLAITS vs. 59.8% in 2001 SLAITS). Connecticut (CT) does remain higher than the national average of 57.4%.

CT's Title V System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), provided a community-based, coordinated system of care for children and families. Contractors provided services to 6,782 CYSHCN in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach and family support.

Through the UConn Medical Center, the Child Health and Development Institute (CHDI) and their subcontractor, the Family Support Network (FSN), conducted the provider and family education, outreach, and family support components of CMHI.

Contractors were identified through a request for proposal to continue the current community-based care coordination model of services, and family representatives participated in all proposal review panels.

CHDI and FSN have been chosen to continue the provider and family outreach and education component of the CT Medical Home Initiative for CYSHCN. The 3-year contracts will focus on family/professional partnerships. Family/professional partners will provide training to families about linking resources, and will work in partnership with primary care providers.

FSN expanded the level of support, information, referral and networking available to families throughout CT. The FSN hosted a forum in May 2009: "Supporting Children with Special Health Care Needs and Families in a Medical Home." The importance of the family/professional partnership was emphasized, and more than 150 people attended the forum from across the state.

Eight family representatives served as voting members of the Medical Home Advisory Council (MHAC) and were compensated for travel and childcare expenses. Family representatives participated in three workgroups, including a Family Experience workgroup. DPH provided stipends to assist families in participation on either Council and/or work group activities, and teleconferencing was available for all meetings. The Family Experience Workgroup requested and received feedback from families on all national performance measures, which highlighted successes and barriers to care for Connecticut CYSHCN, including the need for additional family-centered, community-based, care coordination services. A full copy of the report is available in the Appendix. The Family Experience Workgroup provided significant input into the development of the Medical Home Family Survey, a tool designed to both gather information on medical home care coordination and to provide education.

Families were active members of the legislated Family Support Council, CT Lifespan Respite Coalition, and Family Voices. DPH compensated families to review CT's Title V MCH Block Grant, and invited families to submit written comments on the MCHBG application. The Family Support Council list serve provided information about local and statewide services, and was used to provide creative solutions for needed services and support. A family member was nominated and awarded a family scholarship to the Association of Maternal and Child Health Programs (AMCHP) National Convention in Washington D.C.

DPH partnered with key stakeholders to implement the Health Resources Services Administration (HRSA) grant for the CT Family-to-Family Health Information Network. The project assists

families and providers in navigating public and private health care financing service delivery systems, and in developing appropriate strategies and policies to improve these systems. In November 2009, CT Family-to-Family hosted a daylong presentation on Emergency Medical Services and CYSHCN.

DPH continued to monitor, enhance and revise the statewide respite system available through CMHI. DPH distributed the Get Creative About Respite manual through community activities, and disseminated more than 1,300 copies of Directions: Resources for Your Child's Care, an information organizer that includes sections on medical home and connecting parents and families (in English, Spanish and Portuguese). These documents are available in hardcopy as well as electronically through the DPH website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage families to participate in family forums, CMHI meetings, Medical Home Advisory Council, Block Grant review, Family Support Council and meetings as appropriate.				X
2. Support families to participate through training and mentoring and compensate for time and knowledge.				X
3. Provide trainings for families on statewide and local supports, link families to existing trainings and other resources.				X
4. Have families provide training for all stakeholders and encourage sharing lessons learned.				X
5. Assure families from diverse backgrounds are involved.				X
6. Distribute family surveys.		X		
7. Assure establishment and growth of family/professional partnerships.				X
8. Provide families with tools such as “Get Creative About Respite” and “Directions”.		X		
9.				
10.				

b. Current Activities

Family support services include assistance and culturally-appropriate education to families of CYSHCN that will enable them to acquire skills necessary to access medical and related support services and become empowered, competent supporters for their children.

The Medical Home Family Survey, available in English and Spanish, is posted online and is being distributed through the CMHI.

The Early Hearing Detection and Intervention (EHDI) program is being expanded to include the establishment of a support group for families with children who are hearing impaired. The DPH Family Advocate attended the national EHDI conference in Chicago, gathering information and tools to (1) enhance the EHDI System in CT and (2) achieve family support and care coordination through enhanced linkage with CMHI.

DPH promotes the partnering of families in decision making for CSHCN. Activities include, but are not limited to, compensation for families reviewing the Title V Maternal and Child Health Block Grant application, invitation for families to comment at MCHBG public hearings or focus groups, and distribution of the Get Creative About Respite and Directions: Resources for Your Child's Care manuals.

The DPH Family Advocate is available to the public and all MCH programs within DPH.

Parents Available to Help/CT Family Voices recently presented the DPH Title V CYSHCN Program with the 2010 Pepperidge Farm Outstanding Community Partnership Award.

c. Plan for the Coming Year

DPH and CMHI will support and enhance a family-centered Medical Home concept through statewide outreach and culturally competent education to pediatric primary care providers and families. CHDI and the FSN will implement Family/Professional Partnership education and outreach. CMHI partners and contractors, including the Child Development Infoline of 2-1-1-United Way, will connect families to support, advocacy, and resources.

Eileen Forlenza, Colorado's medical home director, will provide a plenary session on Family/Professional Partnership and Family Leadership at a statewide forum for CMHI contractors, providers, community-based partners, other state agency staff, and families.

CHDI and the Family Support Network will redistribute the Medical Home Survey for Parents, which was originally distributed in July 2008 to survey knowledge regarding medical home and/or provide assistance with establishing or linking with medical homes. Survey results will be compared with 2008 survey data.

DPH will work with key stakeholders and family and consumer agencies, including Kids As Self Advocates, Parent to Parent of CT, Parents Available to Help, and Family Advocacy for Children's Mental Health, Inc., on a collaborative project organized through the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN focusing on transition, with a primary outcome to improve access to a statewide comprehensive, community based, family-centered system of care for CYSHCN and their families.

Families will be active members of the MHAC, its workgroups and subcommittees, the legislated Family Support Council, the CT Lifespan Respite Coalition, and Family Voices. Families will be compensated for their time through stipends for all MHAC meetings and workgroups.

The DPH EHDI program, in collaboration with CHDI and the FSN, will build a family support group for families with children who are hearing impaired.

DPH will participate as an active member of the CT Family-to-Family Health Information Network to assist families and providers in navigating the public and private health care financing service delivery systems, and to develop appropriate strategies and policies to improve these systems.

DPH will promote the partnering of families in decision making for CSHCN. Activities will include, but not be limited to: compensation for families to review CT's MCH Block Grant (MCHBG) application, invitation for families to comment at the MCHBG public hearings or focus groups, distribution of the Get Creative About Respite and Directions: Resources for Your Child's Care manuals, provision and support of an Access database to manage and report information on CYSHCN, and partnership in the Family-to-Family (F2F) Health Information Network management team.

The DPH Family Advocate will serve on the Early Childhood Education Cabinet. The DPH Family Advocate will be available to all MCH Programs within DPH, the CMHI, and family support groups throughout the state.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	56.9	56.9	56.9	48.5	48.5
Annual Indicator	56.9	56.9	48.5	48.5	48.5
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	48.5	48.5	48.5	48.5	48.5

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.
Annual performance objectives for 2009-2013 were updated using these more recent data.

Notes - 2007
Source: The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments
This objective was not successfully met using a comparison of the CT 48.5% reported in the 2005-2006 SLAITS verses the 56.9% reported in the 2001 SLAITS. CT remains higher then the national average of 47.1%.

Connecticut's system of care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), was fully implemented and provided a community-based, culturally-competent, coordinated system of care for children and families. Contractors provided services to 6,782 CYSHCN in the following categories: administration of extended services and respite funds, medical home care coordination, provider and family education, outreach, and family support.

DPH ensured successful implementation of CMHI through technical assistance, training, and support of an Access database used to manage and report data. Bi-weekly CMHI conference

calls were held to address technical assistance needs, and to ensure collaboration and communication between CMHI contractors. Quarterly technical assistance care coordination meetings were held to provide training on specific topics that were self-indentified by the medical home care coordinators.

Contractors were indentified through a request for proposal to continue the current community-based care coordination model of services, and three-year contracts were awarded with an option for two-year renewals. Connecticut Children's Medical Center of Hartford was selected for the North Central area of the state, linking it with St. Mary's Hospital of Waterbury (Northwest), Stamford Health System (Southwest), Coordinating Council for Children in Crisis, Inc. (South Central), and United Community and Family Services, Inc. (Eastern). Expectations included an emphasis on care planning and the provision of technical assistance in building care coordination capacity of the medical home practice staff.

Care coordination activities included: assessment, care planning, home visits, family advocacy, linkage to specialists, linkage to community-based resources, coordination of health financing resources and coordination with school-based services. These services were provided statewide through 32 community-based medical homes.

The DPH Medical Home Advisory Council (MHAC), comprised of more than 40 representatives, including youth representation from Connecticut Kids as Self Advocates, state and private agencies, community-based organizations, and parents of CYSHCN, provided guidance to DPH in its efforts to improve the system of care for CYSHCN by ensuring their connection to a medical home. DPH staff facilitated and attended all monthly MHAC meetings.

The MHAC Family Experience Workgroup focused on educating and informing families on topics such as the MCH Block Grant National Performance Measures, and strategies for advocacy. The Quality Indicators workgroup developed process and outcome-based measures to improve the quality of care coordination in medical homes. These measures were incorporated into the new CMHI contracts and include: continuous systems assessment through a Family Medical Home Survey, the use of comprehensive and emergency care plans, successful linkages to resources, and numbers of children screened for SHCN in individual medical homes.

The MHAC Sustainability Subcommittee developed a Care Coordination Standards document. The document established core competencies for medical home care coordination and was unanimously endorsed by the MHAC membership.

Mark Keenan, CT's title V CYSHCN Director, represented the program by presenting "Care Coordination and the Medical Home" at the annual State and Federal Partnership Meeting. The presentation, made in collaboration with Dr. Richard Antonelli and Beth Dworetzky of Massachusetts Family to Family, was archived on the HRSA website and is given as a resource at all in-state medical home introductory presentations. Medical home presentations were made at Yale-New Haven Hospital Developmental Pediatrics Grand Rounds, Stamford Hospital Family Medicine Grand Rounds, and Stamford Hospital Pediatric Grand Rounds.

In response to a legislative mandates and in consultation with the Medicaid managed care organizations administering the HUSKY A Plans, DPH implemented a medical home pilot project in practice sites located in Hartford, Stamford and Waterbury. The goals of the project were to improve EPSDT services, and to build care coordination capacity in order to enhance health outcomes for children, including CYSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Implement, monitor and evaluate CT Medical Home Initiative.				X
2. Assist the CT Medical Home Initiative with expanding the medical home provider network.				X
3. Work with CT Medical Home Initiative and the Family Support Network to facilitate family-professional partnerships.				X
4. Participate on Medical Home Advisory Council and workgroups.				X
5. Provide families with tools such as “Get Creative AboutRespite” and “Directions”.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMHI provides community-based care coordination services through 34 medical homes statewide. A projected 7,000 CYSHCN will receive care coordination services through CMHI this year.

DPH staff presented an introductory medical home presentation at Yale New Haven Hospital Pediatrics Grand Rounds on March 23, 2010.

CMHI partnership meetings are being conducted in the Eastern and South Central areas of the state. Meetings center around specific families, and include all team members (family, CMHI care coordinators, providers, practice staff, school personnel, managed care organization case managers, CMHI enabling services to include the Family Support Network, CT Lifespan Respite Coalition, Child Development Infoline and others when pertinent - Family Advocacy Organization for Behavioral Health, and CT Epilepsy Foundation, etc.).

Collaborative efforts are being made to align the HUSKY MCO case management program, the DSS Primary Case Management pilot, and CMHI to avoid the duplication of services, to increase care coordination capacity, and to improve quality and efficiency.

In March 2010, the program was represented through a poster session "Medical Home Implementation Served Best By Community-Based Ownership, Connecticut Decentralizes Management and Services" at the National Initiative for Children's Health Care Quality (NICHQ) Annual Forum. The session has generated interest and inquiry from practice sites from both within and from outside the state of Connecticut.

c. Plan for the Coming Year

CMHI will provide community-based, culturally competent medical home care coordination services. Medical home care coordination contractors will include: Connecticut Children's Medical Center (for the North Central area of the state), St. Mary's Hospital (Northwest), Stamford Health System (Southwest), Coordinating Council for Children in Crisis (South Central) and United Community and Family Services, (Eastern). The number of CMHI medical homes is expected to expand to 37, and 7,500 CYSHCN are projected to receive care coordination services next year.

CMHI partnership meetings will expand and be held in all areas of the state.

DPH will provide TA through participation in CMHI partnership meetings, site visits, biweekly conference calls, quarterly TA care coordinators meetings and bi-annual meetings of the entire CMHI. Case scenarios will be shared to ensure access to community-based resources and to

improve referrals and access to the CMHI.

DPH will collect and analyze data from Medical Home Family Surveys. The surveys gather information concerning the child's medical home, care plan, transition plan and care coordinator. The surveys are available in English and Spanish through CMHI care coordinators as well as online. The surveys will also serve as an educational tool and will be used to help determine future areas of focus.

Additional strategies to partner with DSS Primary Care Case Management (PCCM) providers and HUSKY MCO case managers will be developed and implemented. DPH and DSS staff, and HUSKY MCO representatives will participate in the MHAC.

DPH and the MHAC Sustainability Subcommittee will partner with the A.J. Pappanikou Center (University of CT Center of Excellence in Developmental Disabilities (UCEDD)) to develop a public awareness/media campaign to promote the medical home model, and will develop strategies to connect more closely with the broader medical home movement. Participation in a CT Child Health Improvement Program will also be pursued.

The CT Medical Home Learning Collaborative will complete a revision and expansion of the CT Medical Home Training Academy curriculum. The curriculum will be a team-based medical home training comprised of four modules -- "Medical Home Background," "Current Context of Medical Home in Connecticut," "Family-Centered Professional Partnerships," and "Transition for YSHCN." DPH will partner with the UCEDD to post the training modules online.

DPH staff will complete work with developers to migrate the CYSHCN database to a web-based platform. This will allow integration of data with other databases at DPH, and allow for future connection to electronic medical records. The system will allow information from families, medical home based care coordinators and other stakeholders to be integrated in support of CYSHCN program surveillance, planning and evaluation.

Additional medical home presentations will be made to providers, including a project in collaboration with the DPH Primary Care Office.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.3	61.3	61.3	61.7	61.7
Annual Indicator	61.3	61.3	61.7	61.7	61.7
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	61.7	61.7	61.7	61.7	61.7

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.
Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2007
Source: The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments
This objective was successfully met as evidenced by the reported 2005-06 61.7% vs. the 2001 SLAITS 61.3%.

Connecticut's System of Care for CYSHCN: The Connecticut Medical Home Initiative (CMHI) for Children and Youth with Special Health Care Needs, provided a community-based, culturally-competent, comprehensive, accessible, coordinated system of care for children with special health care needs. Contractors provided services in the following categories: administration of extended services and respite funds, community-based medical home care coordination, provider/ family education and outreach. All included facilitating access to adequate public and/or private insurance to pay for services that families needed.

The medical home care coordination and the extended services and respite fund administration contractors provided benefits coordination for families of CYSHCN to assist in accessing public/private sources to pay for services needed, including the facilitation of eligibility determination and application for Healthcare for UninSured Kids and Youth (HUSKY). Under HUSKY, children and youth up to age 19 receive a comprehensive health care benefits package, including preventive care, physician visits, prescriptions, vision care, dental care, physicals, mental health/substance abuse services, durable medical equipment, emergency and hospital care. The Connecticut Lifespan Respite Coalition, the contractor for the management of Extended Services and Respite funds, provided assistance to families in accessing existing insurance benefits and assisting in the process of filing appeals when claims were denied.

DPH served on the legislative Connecticut Medicaid Managed Care Council, a collaborative body consisting of legislators, Medicaid consumers, advocates, health care providers, insurers and state agencies. The Council advises the Department of Social Services (DSS), the state's Medicaid agency, on the development and implementation of Connecticut's Medicaid (HUSKY Part A) and SCHIP (HUSKY Part B) Managed Care program, and ongoing legislative and public input in the monitoring of the program. The Council has a legislative mandate to assess and make recommendations to DSS concerning access to and implementation of the HUSKY program.

The number of participants in the Katie Beckett Waiver remained at 200. The Katie Beckett Waiver enables children to receive an institutional level of care at home, and bases eligibility for Medicaid on income and assets, without counting the income and assets of legally liable relatives.

DSS implemented a Primary Care Case Management (PCCM) pilot in two municipalities, collaborating to facilitate access to PCCM as well as to the Medicaid Managed Care plans. DPH participated on the Medicaid Managed Care Council's PCCM subcommittee.

A FSN forum was held in May 2009 with a focus on supporting CYSHCN and families in a medical home. Presentation topics included the role of the medical home care coordinator and extending the coordination of health financing resources. Resource materials concerning HUSKY eligibility and application and the Katie Beckett waiver were distributed to attendees.

The Child Health and Development Institute (CHDI) was selected to continue the Provider/Family outreach and education component of CMHI with a new focus on Family/Professional Partnership. CHDI subcontracted with FSN to develop and provide training to families, including curricula on accessing public and private insurance.

A training session for CMHI contract grantees took place in June 2009. HUSKY Infoline and DSS staff provided training on information, eligibility, access, and referrals. Training about PCCM was also included.

A day-long forum, "Putting the Pieces Together," was held in December 2009 for CMHI Care Coordinators, Husky Managed Care Organizations (MCO) Case Managers, and CT Dental Health Partnership Care Coordinators (Administrative Services Organization that manages the dental carve out for Medicaid services). Goals were to clarify roles, reduce duplication of services and establish working relationships. DSS Medicaid MCO liaisons and DPH CYSHCN staff coordinated the forum.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assess family's insurance status.		X		
2. Provide education on benefits/services provided byinsurance/other programs.				X
3. RMHSC and Medical Homes identify CYSHCN and provide care coordination including access to private/public insurance.		X		
4. Coordinate with HUSKY Infoline.		X		
5. Work with Medicaid Managed Care Council and DSS toensure CYSHCN population is identified, provided all needed services, and providers are reimbursed for identification and care coordination services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CMHI care coordinators provide coordination of, and facilitate access to, health care financing resources, including public insurance. Referrals are made to the HUSKY Infoline, and assistance is provided in completing application forms.

The DSS Primary Care Case Management (PCCM) pilot was recently expanded to two additional municipalities, (it now includes Waterbury, Windham, Hartford and New Haven). In PCCM, providers are given a per-member per-month payment to provide care coordination in addition to a fee-for-service payment structure. DPH collaborates to facilitate access to PCCM as well as to

the Medicaid Managed Care plans. There are approximately 280 consumers participating in PCCM. DPH sits on the Medicaid Managed Care Council's PCCM subcommittee, which is working to address barriers to enrollment in the pilot.

The DPH Title V CYSHCN Program continues the integration and improvement of strategies for CYSHCN and their families in accessing public/private insurance sources, and assists families with eligibility determination and application for HUSKY.

On March 18, 2010, representatives from all three HUSKY MCOs attended their first MHAC meeting and expressed interest in continued collaboration and participation on the MHAC.

A Family Support Network forum planned for May 2010 emphasizing the connection of medical homes and dental homes will be used as an opportunity to disseminate access and eligibility information to families and providers.

c. Plan for the Coming Year

The DPH Title V Children and Youth with Special Health Care Needs (CYSHCN) Program will continue to integrate and improve access to a quality, comprehensive, coordinated, community-based system of care for CYSHCN within a medical home.

CMHI community-based medical home care coordinators will provide coordination of, and facilitate access to, health care financing resources, including public insurance.

The Connecticut Lifespan Respite Coalition, the contract grantee for the management of extended services and respite funds, will provide assistance to families in accessing existing insurance benefits and in the process of filing appeals.

DPH staff will serve on the Medicaid Managed Care Council and the PCCM subcommittee.

DPH will continue to facilitate access to Primary Care Case Management (PCCM) as well as to the Medicaid Managed Care plans currently offered under HUSKY. DPH will collaborate with DSS and provide technical assistance as PCCM is implemented statewide. DPH staff will continue to participate on the Medicaid Managed Care Council and it's PCCM subcommittee.

DPH and DSS representatives will continue to attend Medical Home Advisory Council and the Family Experience workgroup meetings and respond to issues concerning eligibility determination, access, application process and related issues. DSS staff will participate in CT Medical Home Initiative for CYSHCN contractors' conference calls to address specific insurance issues and questions.

DPH and the Department of Social Services (DSS) will hold additional forums between the Managed Care Organizations' case managers and CT Medical Home Initiative care coordinators to build on the initial steps taken. A DPH summer intern will assist in coordination of activities and develop a resource manual detailing services available in the DSS Managed Care Organization system, the CYSHCN Care Coordination system and the PCCM system. This resource will be made available to all care coordinators, case managers and providers throughout the system, and will include eligibility and access information.

MCO representatives will be offered full MHAC membership and participation.

Additional forums, including FSN and Family-To-Family forums, will be used to disseminate access and eligibility resource materials.

The CHDI and FSN will implement the provider/family outreach and education component of the

Medical Home Initiative for CYSHCN with a new focus on family/professional partnership. The partnership focus will include education for both providers and families of CYSHCN in working together to navigate access to insurance.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76.8	76.8	76.8	89.4	89.4
Annual Indicator	76.8	76.8	89.4	89.4	89.4
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	89.4	89.4	89.4	89.4	89.4

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM05.

Notes - 2008
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.
Annual performance objectives for 2009-2013 were updated using this more recent data.

Notes - 2007
Source: The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments
This objective was successfully met using a comparison of the CT 89.4% vs. the national 89.1% reported in the 2005-2006 SLAITS. Connecticut's System of Care for CYSHCN, "The Connecticut Medical Home Initiative for Children and Youth with Special Health Care Needs" (CMHI), was fully implemented and provided a community based, coordinated system of care for children and families. Contractors provided services to 6,782 CYSHCN in the following categories: administration of extended services and respite funds, medical home care

coordination, provider and family education, outreach and family support.

Five medical home network contractors provided care coordination services statewide. Each network contractor affiliated with and provided embedded care coordination for numerous clinical sites. Care coordination was co-located in community based clinical practices, making care coordination services easier to access for families.

DPH actively advanced the family-centered medical home concept and care coordination for CYSHCN in Connecticut. Together, these ensured that community-based service systems were organized so CYSHCN and their families could use them easily. Central to this system was the development of coordinated care plan templates for use by medical homes with their CYSHCN.

DPH and CMHI staff continued to design trainings and enhanced methods for linking with community based services by utilizing information acquired through the Child Health and Development Institute and the University of Connecticut's Pappanikou Center family surveys that accessed information on the care that CYSHCN received from their primary care provider including provision of information about community based service systems.

Child Health and Development Institute (CHDI) and the Family Support Network (FSN) provided statewide outreach and culturally effective education to 13 pediatric primary care providers and 1,288 families on the concept of medical home for CYSHCN including information regarding access to community service systems. Family support services provided assistance and culturally effective education for families of CYSHCN. This enabled families to acquire the skills necessary to organize their access to needed medical and related support services. FSN hosted "Supporting Children with Special Health Care Needs in a Dental Home" on June 2, 2010, with presentations by the FSN, the CMHI, the DDS Dental Coordinator, and the DPH Office of Oral Health. The event was attended by parents, case managers, school nurses, and others working with children with special health care needs and provided information on how to connect families with dental homes.

DPH collaborated with United Way of CT 2-1-1/Child Development Infoline (CDI) to coordinate referrals to the community-based system. CDI - CMHI/CYSHCN contractor meetings took place to monitor, evaluate and improve referral to the care coordination system of care for CYSHCN. CDI served as a statewide entry point to CMHI.

CT Lifespan Respite Coalition (CLRC) is the DPH contractor managing the administration of Department approved extended service funds and respite funds. Respite and extended services were accessible directly through CLRC, referral from the medical home care coordinators, or through referral from CDI. CLRC served as an additional statewide entry point to CMHI.

DPH maintained public/private partnerships with organizations serving CYSHCN and their families. DPH staff participated on legislated councils, including the CT Family Support Council, Medicaid Managed Care Council, Birth to Three Interagency Coordinating Council, State Department of Education Bureau of Special Education (SDE/BSE) Transition Task Force, Advisory Council to the Division of Autism Spectrum Services, and National Governor's Award Task Force on Transition of Youth with Disabilities to Work. CMHI access information was distributed among these partners as well as to partners involved in the State Implementation Grant for Integrated Community Services for CYSHCN and the Family-to-Family Health Information Center grant. These additional partners included SDE/BSE, Department of Social Services/Bureau of Rehabilitative Services, CT Kids As Self-Advocates, Epilepsy Foundation, Parents Available to Help/ Family Voices of CT, FAVOR (Family Advocacy Organization for Behavioral Health), the CT Family Support Network, the CT Family Support Council, and the A.J. Pappanikou Center Consumer Advisory Board.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement, monitor and evaluate CT Medical Home Initiative for Children and Youth with Special Health Care Needs.				X
2. Implement, monitor and evaluate referral and coordination of services system with United Way of Connecticut 2-1-1 Infoline/Child Development Infoline.				X
3. Work with contractors to survey families regarding access to community-based service systems.				X
4. Develop trainings to enhance families ability to access community-based service systems.				X
5. Enhance public/private partnerships with agencies and organizations serving CYSHCN and their families.				X
6. Implement recommendations from Medical Home Advisory Council strategic planning process.				X
7.				
8.				
9.				
10.				

b. Current Activities

DPH ensures successful community-based implementation of the CT Medical Home Initiative for CYSHCN through technical assistance, training and support of an Access database used to manage and report data. Care coordination services have been expanded to include co-located or embedded care coordination services to 34 medical homes. CDI and CLRC serve as statewide access points. A projected 7,000 CYSHCN will receive care coordination services through CMHI this year.

Through a community-based system of care, DPH and its contractors: reach CYSHCN and their families to assist them with coordination of the multiple systems of care they need to access; provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that optimize the health of CYSHCN; assist PCPs with care coordination for CYSHCN who have high severity needs; assist with coordination between PCPs and specialists; and promote the establishment of medical homes with pediatric PCPs that care for CYSHCN.

CMHI care coordination contractors survey families regarding their access to community-based service systems. Survey results are used to monitor and evaluate the community-based system of care to determine if CYSHCN are receiving coordinated, comprehensive care in their local communities

c. Plan for the Coming Year

DPH will monitor and expand services available through CMHI. The goals of this community-based system of care are: 1) reach more CYSHCN and their families and assist them with coordination of the multiple systems of care they need to access; 2) provide training and support to pediatric primary care providers (PCPs) to improve quality of care by addressing family needs that will optimize the health of CYSHCN; 3) assist pediatric PCPs with care coordination for CYSHCN who have high severity needs; 4) assist with coordination between pediatric PCPs and specialists; and 5) promote the establishment of medical homes with pediatric PCPs that care for CYSHCN.

The system will focus on: 1) increased availability of medical homes for CYSHCN and their

families/caregivers; 2) improved care coordination; 3) technical assistance to medical homes; 4) forums for parent/care-giver interaction through parent/care-giver networks; 5) improved parental/care-giver support, 6) partnership and respite services; and 7) increased stakeholder involvement and collaboration through the Connecticut Medical Home Advisory Council.

CMHI will provide community-based, culturally competent, medical home care coordination services. Medical home care coordination contractors will include: Connecticut Children's Medical Center, (serving North Central CT), Stamford Health System (Southwest), Coordinating Council for Children in Crisis (South Central), United Community and Family Services, Norwich (Eastern) and St. Mary's Hospital (Northwest). The number of CMHI medical homes is expected to expand to 37, and a projected 7,500 CYSHCN will receive care coordination services next year. CDI and CLRC will serve as statewide points of access for CMHI. A contractor identified through a request for proposal will provide family/professional partnership training and support to providers and families, including assistance in accessing CMHI and community-based resources. Quarterly regionally-based meetings will be convened with participants from DPH, the Family Support Network, CDI, CLRC, CMHI locally-based care coordinators, and others to facilitate access to the system and services available to CYSHCN and their families.

Additional partners will be engaged through the State Implementation Grant for Integrated Community Systems for CYSHCN, including the Department of Children and Families. Information pertaining to access to services will be shared with new partners.

DPH will expand dissemination of Directions: Resources for Your Child's Care. This family information organizer is available in hard copy and electronically. It includes sections on accessing the system of services, medical home, health plan information, emergency preparedness, transition, and connecting parents and families. DPH, in partnership with a community-based organization, implemented translation of the document into Spanish and Portuguese, and identified community networks to assist with dissemination.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	43.3	43.3
Annual Indicator	5.8	5.8	43.3	43.3	43.3
Numerator					
Denominator					
Data Source				National Survey of CSHCN	National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	43.3	43.3	43.3	43.3	43.3

Notes - 2009
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM#06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Source: Indicator data come from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for NPM#06; and the 2005-2006 may be considered baseline data.
Adjustments to the annual performance objectives were made for 2009-2013 because of the wording changes to this measure. Adjustments used CT's 2007 figure, which is higher than the national percentage for this measure.

Notes - 2007
Source: The data reported in 2006 are from the most recent national SLAITS Survey. CT has no updates to the national SLAITS Survey data, as reported previously, for national performance measures #2-6.

a. Last Year's Accomplishments
This measure was successfully met (CT 43.3% vs. national 41.2%).

The CT DPH Title V Program was awarded the HRSA State Implementation Grant for Integrated Community Systems for CYSHCN (D70 Grant). The goals of this three-year project are: 1) build system capacity to successfully transition adolescents and young adults with complex health needs and/or disabilities to all aspects of adulthood; 2) nurture linkages between healthcare specialists, educational services, vocational services, out-of-home care, family support, public and private payers to ensure that community services are organized and easy to use; and 3) promote family-centered care by strengthening partnerships between CYSHCN and families/caregivers with primary health care providers in medical homes.

In May 2009, DPH attended the State Implementation Grants Systems of Services for CYSHCN Grantee's meeting in Washington D.C. The meeting was an opportunity for all D70 grantees to share lessons learned about their programs (including successes and barriers experienced in addressing transition), to network and discuss ways in which they can enhance systems of care for YSHCN and their families/caregivers.

In May 2009, DPH hosted a day and evening forum entitled "Keeping the Balance: Children and Youth with Special Healthcare Needs, Families and Professionals Functioning Effectively as a Team." The focus of the forum was transition, and included presentations by Dale Atkins, Ph.D., Ceci Shapland, R.N., M.S.N., Jaideep Talwalker, M.D, and CT KASA youth. The day and evening sessions were attended by more than 150 participants, including individuals representing healthcare, education, mental health, vocational services, the Department of Corrections, the juvenile justice system, the Department of Children and Families, the Department of Developmental Services, as well as community-based organizations, caregivers, families, and YSHCN.

DPH staff and D70 project partners initiated preliminary steps to identify primary care physicians, specialists and family practice providers to provide healthcare services for YSHCN in support of YSHCN transition to adult medical care. Providers were offered participation in the CT Medical Home Learning Collaborative and an introduction to medical home training by DPH staff.

DPH started revision of the Connecticut Medical Home Training Academy Curriculum (CMHTAC). The CMHTAC is a CT specific version of the American Academy of Pediatrics "Every Child Deserves a Medical Home" curriculum. The CMHTAC includes four modules: Background and Current Context of Medical Homes in CT, Care Coordination, Family-Professional Partnerships, and Transition to Adulthood. The curriculum review group includes parents of CYSHCN, healthcare providers, YSHCN and representatives from community-based organizations, disability advocacy groups, CYSHCN care coordinators, State Department of Education Bureau Special Education (SDE/BSE), State Department of Social Services Bureau of Rehabilitation Services (DSS/BRS) and State Department of Children and Families (DCF).

Community-based medical home care coordinators associated with the Connecticut Medical Home Initiative (CMHI) for CYSHCN provided coordinated, comprehensive, family-centered and culturally-effective services, including transition planning by age 14 for YSHCN and their families/caregivers.

DPH care coordination contractors routinely identified and linked CYSHCN and their families/caregivers to multiple services, including healthcare, educational, vocational, respite, recreation, durable medical equipment, and social services. DPH contractors also provided transition planning and coordination services for YSHCN and their families/caregivers.

DPH staff served on the SDE/BSE Transition Task Force (TTF). The TTF supports the SDE/BSE in promoting positive postsecondary outcomes in education, training, employment and independent living for students with disabilities.

In October 2009, DPH co-sponsored "PowerFest 2009: Future Generations", CT's first Statewide Inclusive Youth Transition Festival. The event assisted youth (14--24) with transition to all aspects of adult life. Over 120 youth attended the daylong event. DPH staff administered and collected MCH Consumer Surveys for inclusion in the MCHB five-year needs assessment, as well as Healthy & Ready to Work youth surveys, provided a resource table, and gave a consumer oriented medical home workshop.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify youth with special health care needs.			X	
2. Identify and strengthen relationships with schools, community-based organizations and State Agencies.				X
3. Provide children and families individualized transition packets.		X		
4. Identify and provide training for adult health care providers interested in serving YSHCN transitioning to adult health care.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH is collaborating with the TTF to develop a statewide transition resource webpage for YSHCN and disabilities. The DPH YSHCN webpage template is being linked to the SDE transition resource webpage.

In January 2010, a state project team received training in Washington D.C as part of the HRSA Jumpstart Quality Improvement Program, focusing on "Integrating Systems Strategy for Building Title V Infrastructure." Team members developed and initiated implementation of a quality assurance plan for transition related activities.

In May 2010, the National Center on Cultural Competence (NCCC) conducted a technical assistance visit for the Title V programs and provided a workshop for CMHI contractors, providers, community-based partners, other state agency staff, and families. The focus of the training was assurance of cultural competence in community-based services, including transition services.

In March 2010, the Eastern CMHI Interagency Collaborative held their first Care Coordination & Transition Planning Meeting. The purpose of these meetings is to develop and implement a transition plan for an individual YSHCN and his/her family/caregivers. There were 15 participants at the meeting, including the YSHCN and their families as active partners.

Integrated Services Grant partners meet bi-weekly to revise the CMHTAC. This group is currently revising the Transition to Adulthood Module.

c. Plan for the Coming Year

The CMHTAC Review Group will meet bi-weekly to revise the remaining module of the CMHTAC: Care Coordination. Once the revision process is completed, the CMHTAC will be used to identify and recruit adult healthcare providers who are interested in serving and assisting YSHCN and their families with transition to adult healthcare. DPH will collaborate with the AJ Pappanikou Center -- our state's UCEDD, to convert the CMHTAC into an online training tool for providers and others.

DPH will work with HRSA and the National Initiative for Children's Healthcare Quality to develop, implement and evaluate Interagency Collaboration on Care Coordination & Transition Planning Meetings in all five CMHI regions. These meetings are a continuous quality improvement project developed as a result of CT's participation in the Jumpstart Quality Improvement Program in Washington, DC. DPH will provide guidance and assistance to each regional collaborative during the initial phases of these meetings. Each collaborative will then facilitate four interagency Care Coordination & Transition Planning meetings per year.

The Connecticut Economic Resource Center (CERC) will conduct evaluation activities focused on the transition goals of the D70 grant. These will include: converting the CT Medical Home Family Satisfaction Survey into an online tool; performing an analysis of transition data on the CYSHCN Access Database, Interagency Collaboration on Care Coordination & Transition Planning Meeting pre and post meeting assessments; and developing and analyzing a state specific YSHCN survey that will complement the 2005/2006 National Survey of Children with Special Health Care Needs.

In June, the 2010 Annual CT School Nurse Supervisors Conference will focus on transition. DPH and the State Department of Education/Bureau of Special Education (SDE/BSE) and the Department of Social Services/Bureau of Rehabilitation Services (DSS/BRS) are collaborating with the CT Director of School Nurses to develop the platform for this conference. DPH and SDE/BSE will facilitate a session to increase the understanding of the connection between healthcare and transition and how school nurses can participate in transition planning for YSHCN and youth with disabilities.

In October 2010, CT will host the Division of Career Development and Transition (DCDT) National Conference with the National Secondary Transition Technical Assistance Center (NSTTAC). DPH staff will participate in this conference by sharing the importance of healthcare transition as it relates to YSHCN, and provide DPH CYSHCN program resource materials

(tentative plans are being made to present in a break-out session).

DPH staff and CYSHCN program care coordinators will distribute educational materials to YSHCN and their families/caregivers. Resources will include: Transition and IDEA 2004, Health History, Get Creative About Respite and Directions: Resources for Your Child's Care.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	92.8	88.2	88.6	89	89.4
Annual Indicator	87.8	82.6	83.4	83.2	83.1
Numerator	74327	29686	29765	29207	29091
Denominator	84655	35929	35674	35111	35000
Data Source				CIRTS	CIRTS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	83.6	83.7	83.9	84.1	84.3

Notes - 2009
Source: Connecticut Immunization Registry and Tracking System (CIRTS), 2006 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. The immunization coverage rate for children born in 2006 was 83.1% for the 4:3:1:2*:3:1 series, which represents 35,000 children or 87% of the 40,260 births recorded in CT.
*2 Hib were measured instead of 3 Hib due to the February 2008-July 2009 Hib shortage and deferment of the Hib booster dose.

Notes - 2008
Source: Connecticut Immunization Registry Tracking System (CIRTS), 2005 birth cohort.
The CIRTS data provide a more accurate picture regarding childhood immunization coverage rates for CT children. Immunization coverage rate for children born in 2005 was 83.2% for 4:3:1:3:3:1 series, which represents 35,111 children or 84% of the 41,575 births recorded in CT.

Notes - 2007
Source: Connecticut Immunization Registry Tracking System (CIRTS), 2004 birth cohort.
The CIRTS data provides a more accurate picture regarding childhood immunization coverage rates for CT children. Immunization coverage rate for children born in 2004 was 83% for 4:3:1:3:3:1 series, which represents 35,674 children or 88% of the 40,498 births recorded in CT.

a. Last Year's Accomplishments
CT did not meet the annual objective in 2009. In 2008, Connecticut's 4:3:1:3:3:1 coverage of 69.8% was lower than the 2008 national estimate of 76.1%. CT experienced a significant drop in 3-dose Hib coverage of 14.1 percentage points from 2007 to 2008. This was the only significant

change in single vaccines from 2007 to 2008. Coverage for 3-dose Hib dropped from 96.8% in 2007 to 82.6% in 2008, a significant decrease of 14.1%. The large drop in our 3-dose Hib vaccine series coverage rate, which impacted our overall immunization coverage rate, was mainly attributed to the national Hib vaccine shortage that occurred in November 2007--June 2009. As a result, in December 2007, the CDC issued interim recommendations for the administration of Hib vaccine, requesting that states defer the Hib booster dose for children 12 months of age or older until supply issues are resolved. Children in CT normally complete the 3 dose Hib series by 15 months of age. The booster dose in the Hib series is usually given between 12-15 months of age.

If we look at our registry data for children born in 2006, which is a more accurate indicator than the NIS survey of immunization coverage rate for children in CT, the overall immunization series based on 2-dose Hib coverage scenario, the coverage rate for the 4:3:1:2:3:1 is 83.1%. The Hib vaccine supply shortage and temporary suspension of the Hib booster (3rd) dose has adversely impacted the overall childhood immunization coverage rates.

The Immunization Program was unable to successfully launch a web-based registry application, CT Immunization Registry and Tracking System (CIRTS), to replace our current DOS-based system in 2009. The vendor was unable to deliver a functional system to be deployed to CT's hosting environment. We did not meet our goal of: deploying a new system, bringing 25% of pediatric providers on-line with 95% actively using the new registry to input immunizations real-time for all of their patients under age six by the beginning of 2009.

The Comadrona, state Healthy Start, and Healthy Choices for Women and Children provided case management to pregnant women and their children, and monitored, encouraged and educated parents regarding the importance of keeping well child care visits. The programs assessed immunization status and linked children with primary care providers to maintain up-to-date immunizations. All community health enters follow national guidelines for administration of childhood immunizations. Chart reviews are used to ensure that infants and children are in compliance.

The CYSHCN program assessed children for required immunizations and referred them to appropriate resources. Care coordination is used to support families in accessing services.

The WIC Program encouraged parents and caregivers to obtain well childcare, and referred participants to eligible programs. The CT WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The Immunization Program provided funding to support the CIRTS, as well as 14 contractors to conduct immunization activities, and procure and distribute publicly funded childhood vaccines. Contractor activities consisted of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally-appropriate for pregnant women, new parents, and new immigrants; and providing training and support to medical providers who use the CIRTS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor infants and children for compliance with immunization schedules.	X			
2. Outreach and identify infants and children for up to date immunizations.		X		

3. Provide support, information and linkage to necessary services.		X		
4. Procure and provide publicly purchased vaccines.		X		
5. Provide funding and technical support to health care providers to improve childhood immunization levels.				X
6. Provide WIC check box to identify up to date immunization status.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program is providing funds to support the Connecticut Immunization Registry and tracking system (CIRTS), and funding to 12 contractors to conduct immunization activities, procure, and distribute publicly funded childhood vaccines. Contractor activities consist of: performing clinic immunization assessments to monitor immunization coverage rates for preschool children; coordinating and providing outreach and referrals for children identified by CIRTS who are behind in their immunizations; conducting immunization education campaigns that are culturally-appropriate for pregnant women, new parents, and new immigrants; and providing training and support to medical providers who utilize the CIRTS.

All Title V programs, including CYSHCN and case management programs for pregnant women, assess the immunization status of the infants/children and refer them as necessary to their medical home/primary care provider for any needed immunizations. Those without a designated primary care provider are referred to community health centers.

c. Plan for the Coming Year

The immunization program will: 1) assess and monitor immunization rates, including HEDIS (Health plan Employer Data and Information Set) immunization rates for children enrolled in Medicaid Managed Care; 2) continue efforts in 2010-2011 to build a web-based registry application by exploring the possibility of contracting with the vendor Consilience, the contractor that developed an Immunization Registry product called Maven; 3) convene local advisory/planning groups in all 12 sites funded by that Immunization Action Plan to improve immunization services for children in high risk areas; 4) partner with community organizations, coalitions, businesses and public and private professional and civic organizations to promote childhood immunizations and vaccine safety; and 5) strive to achieve the Healthy People 2010 goal of enrolling at least 95% of children under age six in our immunization registry.

The case management programs for pregnant women (and their children) will ensure that enrolled children are current with their immunizations and will refer to the medical home/primary care provider as necessary to ensure compliance.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.9	12.8	12.3	12.2	11.9
Annual Indicator	12.3	12.3	12.0	11.7	11.7

Numerator	909	914	885	846	846
Denominator	74155	74323	74029	72503	72503
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11.5	11.3	11.1	10.9	10.7

Notes - 2009
Source: CY2009 Vital Statistics data are not available.
The CY2008 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.
Annual performance objectives for 2010-2014 were updated using these more recent data.

Notes - 2008
Source: The CY2008 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.
Annual performance objectives for 2009-2013 were updated using these more recent data.

Notes - 2007
Source: The CY2007 Vital Statistics data are final. The 2005 and 2006 annual objective fields are "locked in" and will not allow us to change the objective to reflect our most recent experience. If we were able to change these fields we would have modified the objective for 2005 to read 12.8 and for 2006 to read 12.3.
Annual performance objectives for 2009-2013 were updated using this more recent data.

a. Last Year's Accomplishments
SBHC staff continued to address teen pregnancy through implementation of risk assessments, and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities and referrals to community-based reproductive health care providers. Counseling and education were also provided to pregnant and parenting teens on numerous topics, including prevention of additional pregnancies. Seven SBHC clinical staff attended an adolescent health conference that featured presentations on contraceptive management for adolescents. SBHCs in the southwestern part of the state conducted a regional conference entitled, The Legal Rights of Adolescents.

DPH funded two adolescent confidentiality teleconferences for community-based health care professionals. A total of 660 individuals registered.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provide risk assessments and referrals for reproductive health services.			X	
2. Implement teen pregnancy prevention programs.		X		
3. Collaborate with traditional and non traditional teen pregnancy prevention partners.				X
4. Develop curriculum for addressing adolescent paternity for at-risk youth.				X
5. Convene the interagency adolescent workgroup.				X
6. Provide education opportunities to key stakeholders on best practices in teen pregnancy prevention and youth development.				X
7. Establish an "Implementation Team" to address reproductive health and sexuality strategic issues identified as a priority in the State Adolescent Health Plan (activities will promote teen pregnancy, STD, and HIV prevention).				X
8.				
9.				
10.				

b. Current Activities

SBHC continues to address teen pregnancy through implementation of risk assessments, and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities, and referrals to community-based reproductive health care providers. The State Adolescent Health Coordinator participates in monthly regional conference calls and shares information related to adolescent health, including updates on the new federal teen pregnancy prevention program with SBHCs and other relevant DPH programs.

The Case Management for Pregnant Women program provides counseling to women at risk for poor birth outcomes.

DPH contracts with the Planned Parenthood of Southern New England Workgroup to provide reproductive health prevention services and education to men and women. There are 12 Planned Parenthood Centers throughout the state, in cities with high rates of teen pregnancies. Over 2,089 teens participated in educational programs presented by Planned Parenthood.

c. Plan for the Coming Year

SBHC staff will continue to address teen pregnancy through implementation of risk assessments, and provision of reproductive health services including: individual/group counseling, health education sessions, student empowerment activities and referrals to community-based reproductive health care providers. The State Adolescent Health Coordinator will continue to participate in monthly regional conference calls, and will provide information on adolescent health including updates on the new federal teen pregnancy prevention program with SBHCs and other relevant DPH programs.

Title V supported programs such as Healthy Start, Healthy Choices for Woman and Children, and the Case Management Program For Pregnant Woman will provide case management to pregnant women, including teens (both female and male) and provide interconceptional counseling. The newly funded Hartford Healthy Stat project will provide care coordination and outreach services to pregnant and postpartum women.

Planned Parenthood will continue to provide reproductive and preventive health education throughout the state.

DPH recently responded to a federal opportunity for teen pregnancy prevention. If funded this

grant in collaboration with the State Department of Education, will bring services to teen mothers to encourage fulfillment of high school requirements.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	30	30	12	38	34
Annual Indicator	26.0	11.4	38.0	18.0	26.1
Numerator	357	2984	1687	4276	6147
Denominator	1374	26171	4440	23747	23535
Data Source				CT Dept. of Social Services SCHIP Division	CT Dept. of Social Services SCHIP Division
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	23.9	23.9	23.9	23.9	23.9

Notes - 2009
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.
Annual performance objectives for 2010-2014 were updated using the most recent data.

Notes - 2008
Source: CT Department of Social Services SCHIP Division. The denominator represents all 8 and 9 year olds enrolled in SCHIP and the numerator represents all 8 and 9 year olds who received dental sealants.

Notes - 2007
Source: The Office of Oral Health developed an oral health status report of children in Connecticut based on the results from oral health basic screening survey (Every Smile Counts) conducted in the 2006- 2007 school year of Head Start, kindergarten and third grade children. Only 38% of the third graders had dental sealants.
Note: The Annual Performance Objectives were updated begining with 2008 based on the more recent data. The annual performance objectives were all set to 38% since it is unknown when the screening survey will be repeated. This objective was unable to be updated for 2007 since TVIS has this field locked.

a. Last Year's Accomplishments
This performance objective was not met. Compared to a projected performance objective of 34%, the annual indicator was 26.1%. Variability in the data makes projection of a realistic objective more difficult.

The "Home by One" program had several achievements during its second year of implementation.
Thirteen "dental homes" were established, consisting of a general dentist within the communities that are serviced by WIC programs to ensure age one dental visits

Over 300 childcare providers were trained in oral health preventive strategies, including fluoride varnish application throughout Connecticut. In addition, 100 WIC nutritionists and other health and social services providers were trained on the importance of early childhood oral health and age one dental visits.

DPH was the recipient of a $1.25 million five-year grant/cooperative agreement from the Centers for Disease Control and Prevention for State-based Oral Disease Prevention Programs and infrastructure development for the Office of Oral Health.

DPH received a $25,000 grant from the National Association of Chronic Disease Directors to address oral health issues of older adults in the state and is in the process of developing a strategic plan to implement goals and objectives identified by the Office of Oral Health's Task force on Oral Health for Older Adults to improve the oral health and overall health of CT's elderly residents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop a strategic plan for enhancing DPH data and information systems to improve the monitoring of dental sealants' prevalence.				X
2. Continue OPENWIDE training of non-dental providers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Office of Oral Health (OOH) is focusing on two major initiatives: "Home by One" and the CDC cooperative agreement. Through Home by One, OOH is developing a statewide infrastructure to increase early childhood oral health interventions. Training modules for child health providers and dental professionals will be made available through web-based curricula.

The CDC cooperative agreement identifies eight core activities on which the OOH should focus: 1) ensuring appropriate staffing for the office, 2) building collaborations with internal/external partners, 3) developing a state oral health plan, 4) ensuring community water fluoridation, 5) creating a statewide oral health coalition, 6) increasing the number of school-based dental sealant programs, 7) enhancing surveillance, and 8) creating an evaluation component. CT has a state oral health plan, strong partnerships, and a mandate that any community water system serving over 20,000 people fluoridate their water supply. OOH is developing a statewide dental sealant program, an oral health coalition that meets the requirements of the CDC, and will conduct a training session for community water operators on the benefits of water fluoridation.

A statewide oral health conference will be held in June to: inform oral heath stakeholders about

OOH programs and activities, state plan implementation, re-engage CT Coalition for Oral Health members, and discuss health care reform's impacts on oral health.

c. Plan for the Coming Year

The Office of Oral Health (OOH) will continue to work toward fulfilling the eight core recipient activities for the CDC Cooperative Agreement. OOH will conduct its second surveillance survey of the oral health status of children. This survey will include height and weight data in addition to the open-mouth survey findings. The focus populations will be kindergarten and third grade students and will be selected through a random sample to be representative of all children in the state.

The CT Coalition for Oral Health will expand to include additional members beyond its core group. Focus areas have been identified, and workgroups will identify activities to implement the CT Oral Health State Plan 2007 -2012 goals and objectives. The group will also begin discussions to develop an updated plan for the next five years.

A dental sealant demonstration pilot will be instituted. This will consist of engaging existing school-based/linked dental programs to use data collection software specifically designed to collect dental sealant data delivered in a school setting. Funding and technical assistance will be provided to participating programs. This will enable the OOH to collect statewide dental sealant data in a more consistent and accurate manner.

The Home by One Program will enter its fourth year and will continue to work toward its goal for all at-risk children to have a dental visit and dental home by age one. In addition, parents who receive oral health and advocacy training will expand to include children with special health care needs. Dental parent advocates will continue to be invited to oral health events and advocacy opportunities. Training for medical and dental providers on age one dental visits, oral health risk assessment, and fluoride varnish applications will become self-sustaining with on-line courses and network development follow-up.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.9	1.5	1.4	1.3	1.2
Annual Indicator	1.6	0.8	1.3	1.0	1.0
Numerator	11	5	9	7	7
Denominator	682998	665901	672521	667742	668663
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	1.2	1.2	1.2	1.2	1.2

Notes - 2009
Source: CY 2009 data are not available.
CT Dept. of Public Health, HISR, CY 2008 final Vital Statistics.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (10, 6, 6) and denominator (668663, 668663, 668663) original numbers.
Annual performance objectives for 2010-2014 were updated using these most recent data.

Notes - 2008
Source: CT Dept. of Public Health, HISR, CY 2008 final Vital Statistics.
The annual indicator is a rolling average of 2006, 2007, and 2008 numerator (5, 10, 6) and denominator (665901, 668663, 668663) original numbers.

Notes - 2007
Source: CT Dept. of Public Health, HISR, CY 2007 final Vital Statistics.
The annual indicator is a rolling average of 2005, 2006, and 2007 numerator (11, 5, 10) and denominator (682998, 665901, 668663) original numbers

a. Last Year's Accomplishments
This measure was met in 2009. Compared to an annual performance objective of 1.2, the annual indicator was 1.1 per 100,000 children. Connecticut addresses this National Performance Measure through Title V and non-Title V programs and collaborations that provide activities designed to reduce deaths and non-fatal injuries due to motor vehicle crashes.

The Injury Prevention Program, using MCHBG funding, developed a contract with Safe Kids Connecticut. Safe Kids conducted 21 child passenger safety workshops for families, healthcare, childcare and community service providers. Last year's workshops primarily focused on families with booster seat age (ages 4-8 years) children. The workshops covered selection of appropriate child restraint systems based on age and size of child, importance of correct use and relevant state laws. The workshops served approximately 351 adults and 500 children. The Family Workshops targeted low-income families and provided booster seats to those who needed them. Workshops were spread geographically throughout the state. Communities included Waterbury, East Haven, New Haven, New London, Lisbon, Plainfield, Colchester, Sterling, Meriden, Manchester, Brooklyn, Clinton, Groton, Naugatuck, Wallingford, Bloomfield, Hartford, and Shelton. Partners and workshop sites included churches, visiting nurses association, Police Athletic Leagues, hospitals, community/neighborhood centers, Head Start/Early Head Start, elementary schools, and a Birth to Three Program.

The Injury Prevention Program, the Family Health Section and the CT Office of Rural Health partnered on the Children's Safety Network's (CSN) facilitated NE Rural Injury Initiative. Representatives participated in conference calls, attended a regional meeting in September as a team, and developed a state action plan, focusing on two injury issues, motor vehicles and suicide/self-inflicted.

The Injury Prevention Program participated in several initiatives that impact motor vehicle injuries and deaths among children, including the CT Department of Transportation's Safe Routes to School, the Safe Teen Driving Partnership, the Capitol Region Council of Governments Pedestrian-Bicycle Committees, the Safe Kids Connecticut Coalition, and the Emergency Services for Children Advisory Committee.

Three local health departments used Preventive Health and Health Services Block Grant (PHHSBG) funding for motor vehicle injury prevention activities.

The Injury Prevention Program provided to units within DPH, individuals, and community-based programs technical assistance on issues related to motor injuries.

The CT CODES (Crash Outcome Data Evaluation System) Project completed linkage of five years of police crash reports to hospital/ED data. CODES data were analyzed for teen drivers, and results were used to support stricter teen driving laws.

The Injury Prevention Program continued to collaborate with partners from the 2008 Governor's Task Force on Safe Teen Driving to address teen driving issues. Enhanced teen driving legislation was passed during 2008.

DPH-funded case management programs, community health centers and school based health centers provided guidance and resources on motor vehicle injury prevention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance, resources, and funding tosupport to motor vehicle injury prevention activities.				X
2. Provide linkages to motor vehicle injury prevention resources.		X		
3. Provide screening, risk assessment and anticipatory guidance in Title V funded programs.	X			
4. Provide guidance and support for policy development regarding motor vehicle related mortality in children.				X
5. Participate in statewide coalitions and collaborations addressing motor vehicle injury prevention through public and professional education, policy change and system enhancements.				X
6. Utilize injury-related data to guide planning for state andcommunity based programs and policy development.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Injury Prevention Program is contracting with Safe Kids CT to conduct at least 18 child passenger safety workshops. The focus will continue to be on families with children of booster seat age because national studies continue to indicate that this age group is least likely to be appropriately restrained while traveling in a motor vehicle.

The Injury Prevention Program, the Family Health Section and the CT Office of Rural Health continue to collaborate on the CSN-facilitated Rural Injury community of Practice. CT injury data is being analyzed to look at differences in motor vehicle and self-inflicted injuries between rural and non-rural towns in CT.

The Injury Prevention Program is collaborating with state and local partners on motor vehicle injury prevention issues.

The Injury Prevention Program is completing analysis for 2005-2007 of injury-related mortality, using hospital and ED data, which include motor vehicle injuries.

The CT CODES Project is completing six consecutive years (2001-2006) of linked motor vehicle crash and hospital/ED data. Additional analysis of data on children in motor vehicle crashes is planned.

Through PHHSBG funding, three local health departments are conducting motor vehicle injury prevention activities during the SFY 2010.

DPH-funded case management programs, CHCs and SBHCs, continue to provide guidance and resources on motor vehicle injury prevention.

c. Plan for the Coming Year

The Injury Prevention Program will use CODES and Injury Surveillance system data to develop and support programs and policies that address the risk factors for motor vehicle injuries among children and adolescents. The Program will work with members of the CODES Advisory Board and other internal and external partners to ensure that the data meet the needs of users and are widely disseminated.

The Injury Program will provide technical assistance to Family Health Section programs, contractors and target populations about motor vehicle injury prevention. The Program will continue to collaborate with the Family Health Section, other DPH Programs such as Day Care Licensing, and Emergency Medical Services for Children, and external partners about transportation safety issues that impact children and adolescents.

DPH-funded case management programs for women and children will work more closely with Injury Program staff to enhance activities and identify resources to reduce the death rate for children age 14 years and under caused by motor vehicle crashes.

SBHCs will have motor vehicle safety as an integral focus of events and services. Community Health Centers, as EPSDT providers, will continue to provide guidance about age-appropriate risk assessments and injury prevention information related to motor vehicle safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		36.8	39	48	49
Annual Indicator	36.8	38.8	43	42.9	41.9
Numerator					
Denominator					
Data Source				CDC National Immunization Survey	CDC National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	45	46.4	47.9	49.3	50.7

Notes - 2009
Source: This measure monitors the rate of breastfeeding at 6 months of age using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2006. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm Annual performance objectives for 2010-2014 have been updated using this more recent data.

Notes - 2008
Source: This measure monitors the rate of breastfeeding at 6 months using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2005. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm

Notes - 2007
Source: This measure monitors the rate of breastfeeding at 6 months using information from the National Immunization Survey based on the year of the birth cohort. The birth cohort reported is the CY 2004. CDC's National Immunization Survey results present estimated breastfeeding rates according to the year of the child's birth to facilitate the evaluation of breastfeeding interventions and progress toward the Healthy People 2010 breastfeeding objectives. Websource: www.cdc.gov/breastfeeding/data/report_card2.htm

a. Last Year's Accomplishments
This measure was not met. The estimated rate of breastfeeding at 6 months of age in CT was 41.9% among infants born in 2006, according to the National Immunization Survey (NIS) 2009 report. This is a one-percentage point decrease compared to the pervious year.

Activities addressing the recommendations in the 2006 Connecticut Breastfeeding Initiative report and the CDC Guide to Breastfeeding Interventions remain ongoing. In June, a third breastfeeding teleconference for physicians was funded by DPH and co-sponsored with the CT Chapter of the American Academy of Pediatrics (CT-AAP). The teleconference was well-received by physicians and other health professionals. A second teleconference was scheduled for December 2009 but postponed because of low registration due to the massive resources needed to administer H1N1 vaccines. Held successfully in March 2010, the second teleconference addressed breastfeeding duration to six months, data, and issues/barriers to breastfeeding duration. DPH provided resources to Title V case management programs for pregnant women (HCWC, Healthy Start, Comadrona, RFTS) and informed them of continuing education opportunities. DPH also continued to provide English/Spanish breastfeeding information sheets for the packets mailed to all new mothers by the Immunization Program.

DPH continued to be actively involved with the CT Breastfeeding Coalition (CBC), participating in monthly meetings and serving on the Board of Directors and conference committee. The DPH Breastfeeding Coordinator also served on the committee that developed CBC's successful application to become one of the first 10 state coalitions to receive funding from HRSA to implement the Business Case for Breastfeeding worksite lactation initiative. In May 2009, the WIC/DPH Breastfeeding Coordinator presented to the case managers working with one of DPH's contractors for the PN Case Management Program.

The WIC Program continued to partially fund the Breastfeeding: Heritage and Pride (BHP) peer counseling program that is jointly administered by the Hispanic Health Council and Hartford Hospital. WIC funds were allocated to replicate the program at Yale-New Haven Hospital during FY 2009. The DPH breastfeeding coordinator chairs a statewide WIC Breastfeeding Committee comprised of coordinators from each local WIC program. The DPH WIC Program maintains an inventory of electric breast pumps that are issued to eligible women who are returning to work or school.

A combination of 75 state and local WIC staff attended the CT-La Leche League conference in

April 2009. WIC funded the 45-hour Certified Lactation Counselor course in New Haven in August 2009.

The breastfeeding initiation rate among WIC infants in CT increased to 62.8% and the 6-month duration rate was 24.4%, based on data submitted to the Pediatric Nutrition Surveillance System in 2008. However, both rates continue to fall below the HP 2010 targets.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attend and participate in the monthly CBC meetings.				X
2. Identify and track breastfeeding data sources to further buildinfrastructure.				X
3. Promote provider and consumer education and awarenessthrough training and education.				X
4. Implement recommendations of provider survey andconsultant analysis of disparities in breastfeeding rates in African American women as appropriate.				X
5. Promote and support the WIC Breastfeeding Peer CounselingProgram.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CBC completed all of the requirements for the Business Case for Breastfeeding worksite initiative pilot. The coalition continues to discuss plans to expand the pilot in the coming year.

Two consumer flyers, one to promote breastfeeding duration and another to raise awareness of CT's breastfeeding laws (including breastfeeding/pumping in the workplace) are distributed to all new mothers in the state through the Immunization Program packets. DPH provides education, support and referrals to mothers to initiate and maintain breastfeeding.

The DPH breastfeeding coordinator retired in 2009. In order for breastfeeding initiatives to remain seamless, a WIC/DPH staff member is filling the position on a part-time interim basis. WIC continues to partially fund the Hartford-based Breastfeeding: Heritage and Pride (BHP) breastfeeding peer counseling program and an expansion of the program to Community Health Services in East Hartford and CT Children's Medical Center is in the planning stages. The Yale-New Haven Hospital (YNHH) BHP Program hired a program coordinator and a full-time peer counselor. The target population for the YNHH BHP Program is the African American population. The WIC Program received additional funding from USDA in FY2010 to expand WIC peer counseling services, the expansion planned with CHS and CCMC will make use of these additional funds. Options are being considered to replicate the WIC Peer Counseling program in other disparate sections of the State.

c. Plan for the Coming Year

All DPH perinatal health programs will provide or refer clients to breastfeeding support services as integrated in their case management activities. A broad array of breastfeeding promotion and support activities will continue to be implemented statewide by the WIC Program. A consultant

continues to assist the WIC Program in implementing the USDA Loving Support: Building Breastfeeding Competencies for Local WIC Staff training program in Connecticut. Trainings scheduled for May, June and September will cover core competencies in breastfeeding for WIC staff in addition to reinforcing some of the breastfeeding messages in the new WIC food packages.

The WIC/DPH Interim Breastfeeding Coordinator will work with the WIC Program Director to identify opportunities to expand WIC peer counseling services in the State with the increase in FY 2010 USDA WIC Breastfeeding Peer Counseling funds.

DPH will participate in monthly meetings of the CBC and committee meetings, as appropriate. World Breastfeeding Week and CT Breastfeeding Awareness Month activities will be planned and implemented. Consumer education materials will be distributed via the Immunization Program's hospital discharge packets and other appropriate vehicles. DPH will continue to participate in the implementation of The Business Case for Breastfeeding and collaborate with the CT Chapter AAP on physician education.

As always, additional resources will be sought to further implement the recommendations in the 2006 Connecticut Breastfeeding Initiative report, in an effort to address racial and ethnic disparities in breastfeeding rates and to improve access to breastfeeding information and support for all families

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98.2	99	99.1	99.2	99.3
Annual Indicator	98.9	99.0	99.1	99.4	98.9
Numerator	41696	41744	41889	40672	39063
Denominator	42142	42186	42266	40930	39481
Data Source				CT DPH EHDI Program	CT DPH EHDI Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99.4	99.5	99.6	99.7	99.8

Notes - 2009
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implimented in CT on 7/1/00. Numerator data collected on 6/16/10.

Notes - 2008

Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00.

Notes - 2007
Source: CT DPH Early Hearing Detection and Intervention Program. Universal newborn hearing screening was implemented in CT on 7/1/00.
The 2007 denominator is provisional data from Vital Records as obtained in April 2009.

a. Last Year's Accomplishments
This measure was not met, as CT's hearing screening rate for CY 2009 was 98.9%, falling short of the Performance Objective of 99.3%. Tracking and follow-up continues on babies born in late 2009, and the provisional rate may improve once final data are available.

CT hospitals have electronically reported newborn screening data to the DPH since 2002. Newborn Screening System (NSS) records are matched to the Electronic Vital Records System (EVRS). The total births reported in the NSS is consistently less than the EVRS annual occurrent birth count. This difference is made up of an unspecified group of babies that may or may not have been born in a CT birth facility versus at home.

The NSS will be replaced by an online reporting system (Maven) within the next year. Once a formal data sharing agreement with Vital Records is in place, the goal is to create a two-way match between Maven and EVRS, which will provide missing demographic information and facilitate tracking and surveillance activities to accurately report the screening status of all occurrent births.

The Early Hearing Detection & Intervention (EHDI) Program's goal is to identify infants with hearing loss as early as possible to minimize speech/language and other delays by linking them to early intervention (EI) services. EHDI has a proactive tracking and follow-up system in place to ensure: 1) all babies are screened at birth; 2) those who do not pass receive timely diagnostic follow-up; and 3) those diagnosed with a hearing loss are enrolled in EI. Bi-monthly reports are sent to hospitals to obtain missing screening results. In an effort to reduce the number "lost to follow-up" (LTF) after an infant fails to pass the newborn hearing screening, letters are sent to the mother and primary care provider (PCP) of any child who fails the hearing screen and for whom DPH does not have a diagnostic audiological evaluation documented. Follow-up phone calls are then made to the child's family and PCP. EHDI is in regular communication with audiology centers about children who were referred from newborn hearing screening. CT's LTF rate was 20.7% in 2008. Enrollment into EI is confirmed for each newborn diagnosed with a hearing loss, and children with a permanent mild and/or unilateral hearing loss are automatically eligible for CT's IDEA, Part C, EI program (Birth to Three). In 2008, 91% of infants diagnosed with a hearing loss were eligible for Birth to Three services.

DPH revised two parent brochures for re-publication in English and Spanish. The "Listen Up!" and "A Parent's Guide to Diagnostic Hearing Testing of Infants" brochures were distributed by CT birth facilities to parents of newborns. Another, "EHDI Program Guidelines for Infant Hearing Screening" was distributed to all 31 birth facilities and one midwife practice. The revised guidelines incorporated new recommendations from the Joint Committee on Infant Hearing 2007 Position Statement, including updated risk indicators and monitoring information.

In April 2009, DPH conducted a one-day educational conference, "Setting the Tone: Providing Assurance to Families," for 30 pediatric audiologists and 36 hospital newborn screening staff. Topics included: communicating results to families, updated hearing screening guidelines, risk indicators for hearing loss, and reducing lost to follow-up.

A survey was distributed to all 31 CT birth facilities to update the EHDI Program regarding hospital newborn hearing screening programs and practices. The results of the survey were compiled to identify program strengths and weaknesses.

The existing Memorandum of Agreement between the DPH, Family Health Section, and the Department of Developmental Services, Birth to Three Program, was renewed and allows for additional data exchange on children with late onset/progressive hearing loss as well as outreach to families of infants born at 28 weeks gestation or less and/or were less than 1,000 grams and thus eligible for EI services.

The DPH EHDI attends monthly CT EHDI Task Force meetings to discuss issues relevant to infant hearing, early identification and habilitation. The CT EHDI Task Force distributed an information-gathering survey to determine how many pediatric PCPs are using OAE screeners in their offices to conduct follow-up testing of infants. The Task Force also began revisiting the group's overall mission and goals for future years, including ensuring active parent participation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Improve state data tracking system.				X
2. Improve follow-up on missed or abnormal screens.				X
3. Improve follow-up on infants lost to diagnostic follow up.				X
4. Improve tracking on follow up program for infants at risk for hearing loss.			X	
5. Educate primary care providers on genetic factors associated with hearing loss.				X
6. Distribute culturally sensitive educational materials to parents.			X	
7. Assure linkage to a medical home.		X		
8. Hire support staff to assist with tracking and follow-up.				X
9.				
10.				

b. Current Activities

DPH EHDI conducts ongoing tracking and follow-up to ensure infants are screened at birth and, when indicated, receive audiological follow up by 3-months of age and are enrolled in EI by 6-months. Phone and on-site technical assistance is provided to hospital staff and audiology centers as needed. Efforts to develop an improved newborn screening reporting system are underway and the DPH project team continues to work with the contractor to model and design the Maven Newborn Screening System.

EHDI is focused on initiatives aimed at reducing the number of babies lost to follow-up (LTF) after failure to pass newborn hearing screening. EHDI has developed an analytical plan to explore LTF differences and identify potential trends to work toward improved tracking and outreach strategies. EHDI staff spoke at a statewide NBS Symposium for birth facilities on their role in reducing LTF in September and presented to University of CT graduate-level audiology and speech language pathologist students in November. The existing contract with the Child Health and Development Institute (CHDI) has been amended to include: (1) development of an EPIC (Educating Practices in the Community) module on EHDI with the intent to improve quality of care related to hearing loss among pediatric-age patients in the primary care setting, and (2) work with the CT Family Support Network to improve information availability and parent-to-parent support for families of children who are deaf or hard-of-hearing.

c. Plan for the Coming Year

EHDI will renew its focus on educating hospital staff, pediatric healthcare providers and families about the importance of follow-up audiological testing of infants within 3-months of age who did not pass newborn hearing screening, as well the importance of monitoring the hearing of children who have been identified with risk factors for late onset/progressive hearing loss. In collaboration with pediatric experts, community service providers and families, CHDI will present the EHDI EPIC module to 20 primary care practices, including practices in each of the state's five CYSHCN Program service areas, and provide each practice with tools and resources to ensure better outcomes in the medical home for children who are deaf or hard-of-hearing.

EHDI has allocated funds to support the goal of increasing parent involvement in the CT EHDI process, including parent-to-parent support. The contract with CHDI includes working to enhance parent involvement in EHDI by partnering with the CT Family Support Network to improve awareness and information availability for families of children who are deaf or hard-of-hearing in CT. Parent feedback will be sought regarding EHDI information exchange, social marketing and educational materials. Additionally, CHDI will explore and assess the level of interest and need for a parent-to-parent support group for families of children who are deaf or hard-of-hearing.

The DPH project team will continue to work with Consilience Software to develop and test the Maven: Newborn Screening System in preparation for implementation. On-site training at all 31-birth facilities and the one midwife practice will be conducted on the new application before it goes live, and a written training manual will be developed for use during the training and implementation phase.

EHDI will collaborate with the CYSHCN Medical Home Initiative to locate children for whom there are no documented follow-up audiological results to determine if an evaluation took place. A CYSHCN module will be developed in the Maven: Newborn Screening System to better integrate program data and facilitate information exchange.

EHDI will begin distributing two national resources developed by the National Center for Hearing Assessment & Management: "Communicate with Your Child" pamphlet for parents of a newly diagnosed young child, and a Newborn Hearing Screening Training Curriculum DVD designed to assist birth facilities with ongoing competency-based training.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.4	8.4	7.6	5.9	5.1
Annual Indicator	8.5	7.7	6	5.2	5.4
Numerator					
Denominator					
Data Source				US Bureau of Census, Current Population Survey	US Bureau of Census, Current Population Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	4.7	4.4	4.1	3.8

Notes - 2009
Source: US Bureau of Census, Current Population Survey, 2008 Table Package, Table HI05.
Annual performance objectives for 2010-2014 were updated based on the most recent data.

Notes - 2008
Source: US Bureau of Census, Current Population Survey, 2007 Table Package, Table HI05.
Annual performance objectives for 2009-2013 were updated based on the most recent data.

Notes - 2007
Source: US Bureau of the Census, Current Population Survey, Table HIA-5, 2006.
Annual performance objectives for 2008-2012 were updated based on the most recent data indicating a steady decrease.

a. Last Year's Accomplishments
This measure was not met. The percent of children without insurance was 5.4%, compared to an objective of 5.1%. Since this measure was first met in 2006, there has been a decrease of 2.3 percentage points. Healthy Start, Family Planning, Community Health Centers, Healthy Choices for Women and Children, and WIC screened families for insurance coverage, and provided support, information and linkages to health care insurance coverage for children. The Case Management for Pregnant Women and Program, initiated in 2008 through a competitive bid process, screened and provided linkages to insurance coverage to families and children in Hartford, New Haven and Waterbury.

Infoline provided MCH information and referral services including access to insurance, and conducted presentations and training to community based agencies and groups regarding the HUSKY program.

A Family-to-Family Health Information forum was held in October 2008. Information and resources available through Title V, public insurance resources, and private insurance information was presented.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach, screening and referral to sources of health insurance.		X		
2. Provide advocacy and liaison to assist families in obtaining health care coverage.		X		
3. Provide education regarding resources to consumers and community-based providers.				X
4. Support the state's information and referral services as a point of access for insurance coverage.			X	
5. Provide follow-up and assistance with insurance application process.		X		
6. Develop capacity with local organization as resources foroutreach and enrollment.				X
7. Provide education regarding resources to consumers and community-based providers.				X

8.				
9.				
10.				

b. Current Activities
State Healthy Start, Family Planning, Hartford Healthy Start, Community Health Centers, Healthy Choices for Women and Children, Case Management for Pregnant Women, medical homes and WIC screen families for insurance, and provide support, information and linkages to health care insurance coverage for children. All MCH programs continue to collect data on the number of uninsured children served.

Infoline serves as the state's single-point-of-entry, toll-free (24 hours/day, 7 days/week) information and referral service for health care coverage. Infoline has a HUSKY line that is dedicated to providing information about the HUSKY program. Both websites for Infoline and the Department of Social Services (administrator of the HUSKY program) provide families with information about the HUSKY program.

c. Plan for the Coming Year
A legislative mandate is being implemented that requires the State Department of Education to identify students who lack health insurance and provide information to their parents about the HUSKY plan. This new mandate, coupled with the protocols in place at each of the DPH-funded SBHC sites to reduce the number of uninsured enrollees, will provide opportunities for increased collaboration between the schools and the SBHC sites to expand HUSKY outreach and enrollment.

Infoline will provide MCH information and referral services, including access to insurance, and will conduct presentations and training to community-based agencies and groups regarding the HUSKY program.

Case Management for Pregnant Women will continue in Hartford, New Haven and Waterbury. Healthy Choices, State Healthy Start, Hartford Healthy Start and WIC will refer women with no health insurance to 211 or to the HUSKY Program.

SBHCs are considering a proposal to study uninsured elementary students to explore the prevalence of those without insurance, identify best practices to increase insurance enrollment, and develop recommendations regarding SBHC practices to enroll more families in HUSKY.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		23.9	9.2	32.1	32
Annual Indicator	24.0	9.2	32.2	31.0	32.0
Numerator	7143	2709	7521	7944	7496
Denominator	29729	29481	23356	25623	23445
Data Source				CDC's Pediatric Nutrition Surveillance System	CDC's Pediatric Nutrition Surveillance System

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31.9	31.8	31.7	31.6	31.5

Notes - 2009
Source - CT DPH , WIC Program, SWIS (State WIC Information System), monthly report on Risk Factors [WICP3003], state-level data for CY2009. Calculated as the 12-month average of children enrolled in WIC aged 2 to 5 years of age by BMI classification, divided by the 12-month average of all WIC children aged 2 to 5 years (23,445), resulting in 3,527 overweight children (or 15.04% with a BMI = 85%ile and < 95%ile), and 3,969 obese children (16.93% with a BMI = 95%ile), for a total of 7,496 out of 23,445 children (31.97%) with a BMI = 85%ile. (Note: 2008 calculation was based on a single month's data.)

Notes - 2008
Source: CDC's Pediatric Nutrition Surveillance System (PedNSS) revealed that 15.7% of children enrolled in the WIC Program in 2008 were at risk of overweight (BMI >= 85th and < 95th percentile) and that 15.5% were overweight (BMI >= 95th percentile). A total of 7,944 out of 25,623 children had a BMI at or above the 85th percentile, for a combined prevalence of 31.2%. Annual performance objectives for 2009-2012 have been left the same for now since one year of results do not reflect a trend. This will be reassessed pending next year's results.

Notes - 2007
Source: CDC's Pediatric Nutrition Surveillance System (PedNSS) revealed that 16% of children enrolled in the WIC Program in 2007 were at risk of overweight (BMI >= 85th and < 95th percentile) and that 16.2% were overweight (BMI >= 95th percentile). A total of 7,521 out of 23,356 children had a BMI at or above the 85th percentile, for a combined prevalence of 32.2% Annual performance objectives for 2008-2012 have been adjusted based on the most recent data.

a. Last Year's Accomplishments
This measure was met when compared to 2008 Connecticut PedNSS data and national figures. The Connecticut PedNSS 2009 annual indicator of 32% of children with a BMI at or above the 85th percentile was 31.2% in 2008, which is slightly below the national figure of 31.3% in the PedNSS 2008 report. The measure was also met based on 2009 Connecticut WIC Program Statewide WIC Information System (SWIS) data (32%).

The local WIC programs in Connecticut continued to use the automated BMI calculation feature in the (SWIS) as a tool for assessing growth, and for teaching parents and care providers about their children's growth patterns. Local WIC nutrition staff continued to provide individual nutrition counseling and group education to participants.

During 2009, the Connecticut WIC Program continued the transition to statewide implementation of Value Enhanced Nutrition Assessment (VENA). This is a national USDA initiative to improve nutrition services in the WIC Program. Its guiding principle is to "strengthen and redirect WIC nutrition assessment from eligibility determination to individualizing nutrition education in order to maximize the impact of WIC nutrition services." Activities included continued collaboration with

the VENA core committee with representation from all local agencies, revisions of policies/forms, and continuing education for local WIC staff. The major focus of the VENA committee shifted toward preparation for the new WIC Food Package Implementation date of October 1, 2009.

The Physician's Outreach Initiative, part of the New WIC Food Package Implementation Plan, began in FY2009. Its purpose is to update health care providers about the WIC Program and the rationale/benefits of the new WIC food packages, inform them of WIC Program requirements, coordinate referrals and networking, and collaborate with them on providing consistent messages with the ultimate purpose of best serving our mutual clients. Five newsletters were distributed and a CT-AAP teleconference was held to emphasize these topics, with major emphasis on the new food packages and changes in policies as a result.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Automate WIC database to generate BMI.				X
2. Training of WIC providers in using BMI.				X
3. Collaboration with WIC local agency VENA committee.				X
4. WIC Physician's Outreach Initiative.				X
5. Collaboration with SNAP –Ed program.				X
6. Promote the positive changes in new WIC food packages.				X
7. Develop/provide WIC educational resources promoting fruits/vegetables and low fat milk.				X
8.				
9.				
10.				

b. Current Activities

WIC Enhanced Nutrition Assessment implementation continues in quality nutrition assessment, participant focused education, standardized nutrition documentation and procurement of standardized educational materials.

The new WIC Food Package revisions include low fat milk only for healthy children, less juice and cheese, and the addition of fruits, vegetables and whole grains. Local agencies were trained on several nutrition education resources promoting fruits/vegetables and low fat milk. Packets of these were sent to local WIC agencies in March 2010 to celebrate National Nutrition Month and promote fruits/vegetables and low fat milk.

The CT State WIC Office collaborated with the Supplemental Nutrition Assistance Program (SNAP-Ed) Program in a joint initiative involving the SNAP-Ed Program providing "Loving Your Family, Feeding Their Future" group education classes at local WIC agencies. The SNAP-Ed Program has also adapted several low-cost recipes, which include CT WIC-approved foods promoting fruits and vegetables that can be distributed to participants who are SNAP-eligible. A follow-up workshop is planned with the SNAP-Ed staff and local WIC agencies. A summary of lessons learned from the trial classes, best practices, and the development of lesson plans/tools to utilize the SNAP-Ed resources within the WIC Program will be explored.

A CT AAP teleconference on obesity, sponsored by the CT DPH and coordinated by the CT WIC Program, is being planned for later this year.

c. Plan for the Coming Year

The WIC Value Enhanced Nutrition Assessment (VENA) committee will continue to work on quality nutrition assessment, participant-focused education, standardized nutrition documentation, and procurement of standardized educational materials. Goal setting with participants and emphasizing behavioral change will be explored as well.

The Physician's Outreach Initiative will continue in FY2011 and explore development of consistent messages/resources for our mutual client bases.

USDA's core nutrition objectives, designed to enhance optional nutrition and feeding relationships between family members, will be promoted and integrated into WIC nutrition education messages.

Collaboration will continue with the SNAP-Ed program, based on outcome of the 2010 trial SNAP-Ed classes at local WIC agencies and subsequent follow-up workshop feedback.

WIC will begin to work on a new data measure tracking BMI rates among children in WIC who are 2-5 years of age and who were breastfed, compared to those who were not breastfed.

WIC will consider the feasibility of future tracking of BMI rates among children 2-5 years of age whose mothers gained more than the recommended weight during pregnancy, based on the Institute of Medicine's new weight gain guidelines during pregnancy.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		3	0.2	0.2	0.1
Annual Indicator	3.1	0.2	0.2	0.2	0.2
Numerator		84	79	65	65
Denominator		41461	40969	39854	39854
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0.1	0.1	0.1	0.1	0.1

Notes - 2009
Source: CY 2009 data are not available.
CY2008 final data, CT DPH, Vital Statistics. Similar to 2005, 2006 and 2007 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column was based on the removal of data where prenatal care and tobacco use

in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

Notes - 2008
Source: CY2008 final data, CTDPH, Vital Statistics. Similar to 2005 and 2006 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

Notes - 2007
Source: CY2007 final data, CTDPH, Vital Statistics. Similar to 2005 and 2006 calculations, percent is based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. It has been noted that this figure is very low, however, this information is self-reported by the mother on the birth certificate.

Note: The 2005 column was based on the removal of data where prenatal care and tobacco use in the third trimester was unknown. The calculations reported a numerator of 89 and a denominator of 41,086 resulting in an annual indicator of 0.2%. This column is locked and so these updates are not possible to this form.

a. Last Year's Accomplishments
The Connecticut Quitline received 7,753 calls providing counseling and referral to Connecticut residents about tobacco use cessation. Through funding received during FY 2009, the Quitline is currently offering services and nicotine replacement therapy products of patches, gum or lozenges. All residents are eligible, and Medicaid participants and the uninsured are able to receive eight weeks worth with participation in the multiple-call program.

Quitline materials continue to be distributed through a wide variety of venues, including health care providers, community health centers, state and local libraries, and other community programs. An emergency room and pharmacy pilot that distributes Quitline information and referrals are both occurring. Providers can fax a referral sheet directly to the Quitline, who will then contact the patient directly.

During the fall of 2009, another state tax increase on each pack of cigarettes went into effect, causing a rise in the number of calls to the Quitline and an anticipated drop in youth initiation.

The Tobacco Control Program continued to provide funding to six federally-qualified community health centers for tobacco use cessation programs focused on pregnant women and women of childbearing age. These programs began in November 2008 and will run through June 2010. Six additional community programs are funded for the period beginning November 1, 2009 to June 2011, which will provide services to additional participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide cessation counseling and referral through the CTQuitline.	X			
2. Educate health care professionals and providers in cessation				X

intervention and treatment.				
3. Educate public about the effects of tobacco use and secondhand smoke.			X	
4. Screen and refer women to smoking cessation programs.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Additional funding for community tobacco use cessation programs has been received and will be awarded during CY 2010, along with extended funding for specialized services targeting the mentally ill.

The DPH Tobacco Use Prevention and Control Program continues to work on the implementation of tobacco use cessation programs at all contracted agencies. An independent evaluation is underway that will collect data and results to determine the effectiveness and cost efficiency of all programs. These results will be used for future planning efforts.

During the spring of 2010, DPH unveiled a media campaign that will promote the use of the Quitline, which will also provide referrals to the community programs. A youth prevention program has kicked off, which includes a video contest for youth that will provide the opportunity for them to develop a television commercial that will become part of a statewide campaign during the fall of 2010.

A grassroots campaign will be running during the summer of 2010, which will provide opportunities to share information about Quitline services currently available and the hazards of exposure to second hand smoke.

c. Plan for the Coming Year
All programs that receive funding must incorporate tobacco use screening into their systems processes. This practice will continue, with the expectation that screening and referrals to available tobacco use cessation resources will be ongoing. With the availability of telephonic, online, and face-to-face programs, it is anticipated that many of CT residents who wish to quit using tobacco will have the opportunity to do so.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2.5	2.5	3.8	6.4	6.3
Annual Indicator	4.0	6.4	5.2	5.6	5.6
Numerator	10	16	13	14	14
Denominator	247415	250071	249493	250373	250367
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5.5	5.5	5.4	5.4	5.3

Notes - 2009
Source: CY2009 data are not available.
CT Dept of Public Health, Vital Statistics final CY2008 data.
The annual indicator is a rolling average of 2007, 2008, and 2009 numerator (13, 14, 14) and denominator (250994, 250053, 250053) original numbers.
Annual Performance Objectives for 2010-2014 have been updated based on the most recent data.

Notes - 2008
Source: CT Dept of Public Health, Vital Statistics final CY2008 data.
The annual indicator is a rolling average of 2006, 2007, and 2008 numerator (16, 13, 14) and denominator (250071, 250944, 250053) orginal numbers.
Note: The Annual Performance Objectives for 2008 and 2013 have been updated based on the most recent data.

Notes - 2007
Source: CT Dept of Public Health, Vital Statistics final CY2007 data
The annual indicator is a rolling average os 2005, 2006, and 2007 numerator (10, 16, 13) and denominator (247415, 250071, 250994) orginal numbers.
Note: The Annual Performance Objectives for 2008 and 20013 have been updated based on the most recent data.

a. Last Year's Accomplishments
Community Health Centers (CHCs) provide mental health services through assessment, direct care and/or referrals. During the last fiscal year, 24,601 mental health clients were served in ten FQHCs. They continue to ensure these mental health services through direct provision via onsite clinicians such as social workers, psychiatrists and psychologists and through referrals to community agencies such as local hospitals, child guidance centers and mental health centers. The CHCs are working closely with the Child Guidance Centers across CT, and some of the Child Guidance Centers are operated by CHCs.

SBHCs continue to provide anticipatory guidance and mental health risk assessments at all locations. Other mental health services include crisis intervention, individual, family, and group counseling, and referral and follow-up for specialty care. All SBHCs offer services directed at high-risk populations, such as youth with suicidal thoughts/attempts.

Through the use of a specially designed mid-year report, SBHC sites reported on the following mental health related issues: successes in service delivery, trends, gaps/barriers, and potential solutions.

Thirty-five individual SBHC mental health clinicians received Master Therapist training funded by DPH. Clinicians may opt to attend workshops covering diverse mental health issues. A total of 52 workshops were funded this year. A total of 26 therapists attended the workshop on bipolar disorder in adolescents.

Healthy Choices for Women and Children provides comprehensive assessment of clients,

including the need for mental health services. Referrals are initiated as necessary. This program continues to identify and refer clients who are at risk for suicide to appropriate resources.

MCHBG funds were used to support a consultative hotline about perinatal depression for healthcare professionals in the state. A set of grand rounds was also implemented through 9/30/10 to highlight the need for perinatal screening.

There were also non-Title V funded activities. The Injury Prevention Program provides guidance related to suicide prevention information, data and resources, when requested to other DPH programs.

FHS staff participated in the Women's Health Subcommittee of the Medicaid Managed Care Council, which focused on issues related to perinatal depression.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide suicide prevention training to students.				X
2. Provide suicide prevention training to providers and other adults.				X
3. Provide technical assistance and guidance for MCH programs.				X
4. Provide anticipatory guidance and risk assessments in Title V funded programs, especially SBHCs.		X		
5. Provide mental health services through assessment, direct care and/or referrals in SBHCs, CHCs and other MCH programs.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

School Based Health Centers (SBHCs) are providing anticipatory guidance, risk assessments and mental health therapy at all locations. Staff are working with SBHCs to enhance data collection tools related to mental health service delivery at these centers.

Community Health Centers provide mental health services through screening, assessment, primary care, and referrals.

The Case Management for Pregnant Women and Teens Program includes screening for perinatal depression. This program covers the towns of Hartford, New Haven and Waterbury. Perinatal depression screening occurs in the state Healthy Start programs and Hartford Healthy Start that provide case management services for pregnant women (and teens) at or below 185% of the FPL.

c. Plan for the Coming Year

Hartford Healthy Start and Case Management for Pregnant Women and Teens will continue to screen for perinatal depression and other case management programs such as Healthy Start and HCWC.

CHCs will continue to provide mental health services through assessment, direct care, and/or

referrals. The FHS will continue to participate on the Women's Health subcommittee of the Medical Managed Care council, which has a special focus on perinatal depression.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	87.5	87.3	87.4	87.5	87.6
Annual Indicator	87.1	86.3	84.9	86.4	86.4
Numerator	580	591	541	538	538
Denominator	666	685	637	623	623
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86.5	86.6	86.7	86.8	86.9

Notes - 2009
Source: CY 2009 data are not available.
CY2008 final data, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.
Annual performance objectives for 2010-2014 have been updated based on the most recent data.

Notes - 2008
Source: CY2008 final data, CT DPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

Notes - 2007
Source: CY2007 final data, CTDPH, Vital Statistics. Eleven of CT's acute care hospitals with self-declared NICU's were included in this survey.

a. Last Year's Accomplishments
This objective was not met. CT has 30 birthing hospitals statewide and one birthing center located in Danbury, CT, contiguous to the New York State border. There are 11 "self-defined" Level III Neonatal Intensive Care Units in CT.

The State Perinatal Health Advisory Committee, which is now part of the MCH Advisory Committee, met quarterly as scheduled. One plan recommendation identifies the need to reduce pregnancy and birth related risk factors by facilitating maternal transfers to tertiary perinatal/neonatal centers for high-risk antepartum, intrapartum and postpartum care.

The Title V-funded programs, including State Healthy Start, CenteringPregnancy, Case Management for Pregnant Women, Family Planning, and Healthy Choices for Women and Children, provided outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers. Through a case management approach,

women identified as at-risk were referred for appropriate evaluation.

A Strategic Plan within the FHS was developed May 2008, and later updated in February 2009. The plan addresses low birth weight and its disparities. The following activities have been completed: 1) two community-based health care centers were funded to initiate the CenteringPregnancy model of group prenatal care; 2) a statewide infant mortality campaign was expanded to incorporate lifecourse theory; 3) dissemination of a brochure about fish consumption during pregnancy was broadened; 4) recommendations of an agency-wide workgroup to address disparities in low birth weight within Hartford; 5) DPH applied and received funding to build a Healthy Start community within Hartford; 6) DPH developed an MOA to share low birth weight records with the state's Birth-to-Three program; 7) the FHS included lifecourse theory in its state priorities, and 8) using a technical assistance grant with HRSA funding, the FHS conducted a statewide symposium to address disparities in the CT's perinatal system of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach, identification and referral of high-risk pregnant teens.		X		
2. Provide intensive case management and supports to promote positive pregnancy outcomes.		X		
3. Provide culturally competent and linguistically appropriate care to high-risk populations.	X			
4. Collaborate with tertiary care centers that provide specialized delivery and neonatal care.				X
5. Collaborate with the members of the State Perinatal Health Advisory Committee to implement the plans goals and objectives.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

State Healthy Start, Hartford Healthy Start, Family Planning, Healthy Choices for Women and Children, and Community Health Centers assess and refer high-risk pregnant women to facilities for high-risk deliveries and neonates. The Case Management for Pregnant Women Program promotes case management for pregnant women and teens in Hartford, New Haven and Waterbury. This program will continue to provide outreach, screening, case management and referral for high-risk pregnant women to specialists and tertiary care centers.

The MCH Advisory Committee meets quarterly. The MCH Advisory Committee is the vehicle for discussing and implementing the recommendations from the State Perinatal Plan, and specifically reviewing the activities and resources needed to better address this NPM.

Recommendations identified in the recently developed Strategic Plan for Addressing Low Birth Weight in CT, include the need to coordinate with medical providers to ensure that high-risk pregnancies deliver in tertiary care hospitals.

c. Plan for the Coming Year

State Healthy Start, Hartford Healthy Start, Family Planning, Healthy Choices for Women and Children, Case Management Program For Pregnant Women, and Community Health Centers will provide outreach, screening, intensive case management, and referral for high-risk pregnant women to specialists and tertiary care centers.

The CenteringPregnancyÒ program provides group prenatal services and education to women at risk for poor birth outcomes. The programs are located at the Fair Haven Community Health Center and the Hospital of St. Raphael in New Haven, CT.

The MCH Advisory Committee will continue to meet and identify resources, and develop and implement strategies to better address this objective.

FHS Epidemiologist will conduct a more in-depth review of the birth data, to better assess where (which facilities) the VLBW are occurring, and look for any trends or other indicators that might better explain this gradual decrease.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.9	87.8	87	87.3	87.6
Annual Indicator	86.7	85.8	86.5	87.6	87.6
Numerator	35654	35303	35424	34898	34898
Denominator	41103	41161	40969	39845	39845
Data Source				DPH Vital Statistics	DPH Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88.5	88.9	89.4	89.9	90.4

Notes - 2009
Source: CY2009 data are not available. CY2008 final, CT DPH Vital Statistics.
Annual performance objectives for 2010-2014 have been updated based on the most recent data.

Notes - 2008
Source: CY2008 final, CT DPH Vital Statistics.

Notes - 2007
Source: CY2007 final, CT DPH Vital Statistics.

a. Last Year's Accomplishments
The objective was successfully met. Compared to an objective of 87.6% of women receiving early prenatal care, the indicator was 88.0%. Pregnant Women referred to State Healthy Start, Healthy

Choices for Women and Children, Case Management for Pregnant Women, Family Planning, School Based Health Centers, Community Health Centers and WIC programs were screened for a primary care provider and health insurance, and were referred for services in promoting the benefits of early and continuous prenatal care.

The Centering Pregnancy(r) model of group prenatal care was implemented in New Haven at two sites. This model provides group prenatal care and education to women most at risk for delivering low birth weight infants and promotes early access to prenatal care.

The First Time Motherhood/New Parents Initiative Grant was received from HRSA to develop, implement, evaluate, and disseminate novel social marketing approaches that concurrently increase awareness of existing preconception/interconception, prenatal care, and parenting services/programs in Hartford and New Haven and address the relationship between such services and healthy birth outcomes. A public awareness campaign regarding infant mortality, particularly among African Americans and encouraging early entry into prenatal care, was initiated in the Greater Hartford and New Haven areas using radio and television.

A workgroup with DPH was convened to address the issue of health disparities. As a result, a strategic plan was developed, which included the objective in Hartford to address low birth weight, which often results from late or inadequate prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide outreach and case management to identify and enroll clients in early prenatal care.		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services.	X			
3. Provide outreach to targeted populations (i.e. pregnantsubstance users).		X		
4. Provide support, information and advocacy to pregnant teens.		X		
5. Continue to analyze and disseminate PRATS Survey data.			X	X
6. Provide pregnancy testing, reproductive health education, counseling and linkage to healthcare providers.	X			
7. Develop a statewide fetal and infant mortality surveillance program.			X	X
8. Promote early enrollment into prenatal care as a linkage from programs such as WIC.		X		
9. Provide/promote comprehensive services to encouragewomen of reproductive age to enter prenatal care early.		X		
10.				

b. Current Activities

WIC, State Healthy Start, Hartford Healthy Start, Family Planning, School Based Health Centers, Healthy Choices for Women and Children, and Case Management for Pregnant Women, and Community Health Centers encourage early entrance into prenatal care.

A recently implemented First Time Motherhood campaign incorporates messages about the importance of early and regular prenatal care, as well as promotion of protective factors like exercise, diet, and healthy behaviors. This television campaign is focused on African American women in the Hartford, New Haven and Bridgeport communities.

The Centering Pregnancy model of group prenatal care continued in New Haven at two sites to

provide group prenatal care and education to women most at risk for delivering low birth weight infants and promote early access to prenatal care.

The following recommendations from the LBW Strategic Plan have been initiated: 1) facilitate case management services for first time pregnancies; 2) coordinate with medical providers to ensure evidence-based treatment for pregnancies at risk of preterm-birth; 3) advertise the use of Infoline 2-1-1 to assure referrals for early and regular prenatal care; 4) document that all DPH-funded initiatives address language, culture, diversity and health literacy; and 5) continue to provide technical assistance to the Hartford Health Department in support of their recent federally-funded Healthy Start Program.

c. Plan for the Coming Year

Title V programs State Healthy Start, Healthy Choices for Women and Children, CenteringPregnancy and the Case Management Program for Pregnant Women will provide outreach and identification of pregnant women to promote early entry into prenatal care. The contractor reporting forms will be revised to include collection of the trimester of pregnancy at mother's time of enrollment. Programs not fully funded by the MCH Block Grant, including Family Planning, School-Based Health Centers, Community Health Centers and WIC, will promote early entry into prenatal care. Hartford Healthy Start is also performing active outreach in Hartford to women in early pregnancy.

D. State Performance Measures

State Performance Measure 1: *Cumulative number of datasets incorporated into integrated warehouse (called HIP-KIDS).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		3	2	3	4
Annual Indicator	2	2	2	2	2
Numerator	2	2	2	2	2
Denominator	7	7	7	7	7
Data Source				FHS staff	FHS staff
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	5	6	7	7	

Notes - 2009

Source: The number of databases linked as part of HIP-Kids remained at 2. The focus remained on the migration of the NSS to the PHIN platform for the EHDI and BDR databases. Delays in the successful migration of all three NSS components continued to be due to the Genetics/ Laboratory Tracking agreeing to also migrate after approximately 8 months into the project. Genetics/ Laboratory Tracking rejoined this project in mid summer of 2009 which unfortunately was quickly followed by a several month dictate by the state's Dept. of Information Technonolgy (DoIT) to stop and reevaluate all MAVEN migration activities. By early 2010, DoIT had reactivated these activities and allowed the Genetics/ Laboratory Tracking staff to restart migration to the MAVEN application.

Notes - 2008

Source: The number of databases linked as part of HIP-Kids remained at 2. During CY2008 the focus remains on the migration of the migration of the NSS to the PHIN platform the EHDI and

BDR databases, now referred as the Newborn Health Profile, more successfully migrated. Delays in the successful migration of all three NSS components was due to the Genetics/ Laboratory Tracking agreeing to also migrate after approximately 8 months into the project.

Notes - 2007
Source: The number of databases linked as part of HIP-Kids remained at 2. Database linkages were put on hold due to the shift of DPH's focus on the migration of databases to a standardized network platform that met IT state-of-the-art requirements.
Adjustments were made to the 2008-2012 annual performance objectives due to this change in plans.

a. Last Year's Accomplishments
Using funds supplied by the Environmental Public Health Tracking program, and the Early Hearing Detection & Intervention (EHDI) Infrastructure grant, the EHDI and Birth Defects staff worked with a consultant firm Consilience Software, Inc. staff to complete the phases of the migration to the Public Health Information Network (PHIN) platform using Consilience's recommended IT application, MAVEN. These two components of the Newborn Screening system, now referred to as the Newborn Health Profile (NHP), were scheduled to start training hospital staff in the summer 2009. This was pushed to the end of the year after the Genetics/Laboratory Tracking staff decided to also migrate the genetic screening component of the NSS to MAVEN. The Genetics/Laboratory staff worked with Consilience staff to identify their business requirements for the MAVEN application. These efforts will continue until the fully developed system is in production (planned for April 2011).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prepare for the migration of the CHP database to the PHIN platform by documenting the business needs of the NSS.				X
2. Pursue funding for HIP-Kids project.				X
3. Continue to participate on the Department-wide Data Committee.				X
4. The electronic reporting system, CHIERS, was updated.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
FHS staff continued their efforts to migrate current EHDI and BDR data into the MAVEN application. We successfully convinced the Laboratory Tracking staff to allow their component of the NSS to be migrated along with the EHDI and BDR databases. Additional funding was secured that will allow the CYSHCN database also to be migrated into MAVEN.

One barrier to successfully meeting the project's original timeline is that the CT Department of Information Technology (DOIT) placed a temporary hold on all MAVEN projects until late 2009 through early 2010. The revised "Go-Live" date for this project is now estimated to be April 2011. Once completed, the EHDI, BDR, Genetic/Laboratory, and CYSHCN programs will have an integrated web-enabled, electronic messaging capable, secure surveillance system that will improve the efficiency of data collection, case monitoring and data analysis.

The electronic death record system is currently being upgraded and therefore, linkage of these records to the MAVEN application will be delayed. The Immunization Registry was selected as the next database for integration into MAVEN. We successfully obtained the support of an IT Project Manager for the Immunization MAVEN project, which has contributed greatly towards facilitating the aggressive time frame for implementation. Integration of the Immunization Registry into MAVEN should be completed by December 2011.

c. Plan for the Coming Year
Needs Assessment identified a similar SPM and will continue work on this project.

State Performance Measure 2: *Cumulative number of formal agreements, in the format of Memoranda of Agreements (MOA's) and collaborative agreements, that serve the needs of the three MCH populations.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13	17	21	28
Annual Indicator	12	16	20	25	29
Numerator					
Denominator					
Data Source				Survey of FHS programs	Survey of FHS programs
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31	34	37	40	

Notes - 2009
Source: CY2009 data are from a survey of FHS programs.

Notes - 2008
Source: CY2008 data are from a survey of FHS programs.
Adjustments were made to the 2009-2013 annual performance objective based on this most recent data.

Notes - 2007
Source: CY2007 data are from a survey of FHS programs.
Adjustments were made to the 2008-2012 annual performance measures based on this most recent data.

a. Last Year's Accomplishments
MOA between DPH -- Dept of Education re CYSHCN (8/15/08-6/30/11): Commits lead staff to participation in a learning collaborative and collaboration for improvement of transition and other services for CYSHCN.

MOA between DPH -- DSS/BRS re CYSHCN (8/15/08-6/30/11): Commits lead staff to participation in a learning collaborative and collaboration for improvement of transition and other services for CYSHCN.

MOA between DPH -- DCF re CYSHCN (9/01/09-6/30/11): Commits lead staff to participation in a learning collaborative and collaboration for improvement of transition and other services for CYSHCN.

MOA between DPH -- DDS re. CYSHCN: Facilitates referral to Birth to Three System for Newborns referred by UNHS for assessment. Refers all newborns under 1,000 grams birth weight to Birth to Three for outreach.

MOA with UCONN's School of Nursing for PCO includes awareness and after school activities and targets high school students from urban high schools and Boy Scouts and Girl Scouts considering health careers.

MOA between DPH -- DSS re. Healthy Start: DSS, through its subcontractors, provide case management services to eligible pregnant women for the purpose of improving birth outcomes by reducing the rate of infant mortality, morbidity and low birth weight in Connecticut, and provides such women with access to prenatal/postpartum care services through Connecticut's HUSKY A health coverage program, in order to promote and protect the health of both mother and baby.

MOA between DPH -- UCONN/Eastern AHEC: UCONN Eastern AHEC conducted surveys and research through funding from CDC's Rape Prevention Education Grant to develop a Sexual Violence Prevention Toolkit and Resource Guide that highlights sexual violence prevention resources, tools and services in the state and a video that included interviews with key partners to raise awareness regarding sexual violence as a public health issue.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Identify collaborating partners at the state and local level.				X
2. Inventory existing collaborations.				X
3. Identify gaps in existing collaborations and opportunities for new partnerships.				X
4. Monitor the effectiveness of collaborations and interventions.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

c. Plan for the Coming Year
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

State Performance Measure 3: *Percent of 9-12 graders who reported being in a fight within the past 12 months.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective		32.7	32.6	32.6	32.5
Annual Indicator	32.7	32.7	31.4	31.4	28.3
Numerator	715	715	630	630	658
Denominator	2185	2185	2007	2007	2324
Data Source				CDC's YRBS national surveys	CDC's YRBS national surveys
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	32.5	32.4	32.4	32.3	

Notes - 2009
Source: CDC's YRBS 2009 national survey (from summary weighted data) .

Notes - 2008
Source: This survey is conducted every other year in conjunction with CDC's YRBS national surveys. The next survey is being conducted in 2009.

Notes - 2007
Source: This is weighted 2007 CT High School Survey (formerly called YRBS) data.

a. Last Year's Accomplishments
The Connecticut School Health Survey (CSHS) was conducted in the spring of 2009. Results from this survey showed that 28.3% of students were in a physical fight one or more times during the past 12 months. This was a slight decrease from the 2007 CSHS figure of 31.4%.

SBHCs statewide continued to provide individual, family and group counseling to enrolled students and their families and conducted health education, promotion and risk reduction activities related to violence prevention that were available to the entire school population.

Continuing education opportunities were offered within available resources so that SBHC mental health clinicians could continue to build clinical capacity to address fighting and other violent behavior among students in grades 9-12.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Trends related to the number of students who reported being in a physical fight in the past year will be monitored with the completion of the 2006 CT School Health Survey.			X	
2. Creation of opportunities for teen employment and workforce skill development.				X
3. Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills.				X
4. Increase the number of schools that have peermediation/conflict resolution and social development programs.				X
5. Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents.				X
6. Support efforts to reduce availability of weapons.				X

7. Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds.				X
8. Reduce demand for drugs through substance abuseprevention and treatment strategies.				X
9. Support efforts at the community level.				X
10.				

b. Current Activities
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

c. Plan for the Coming Year
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

State Performance Measure 4: *Percent increase in the number of adolescents 10-20 years old who receive services in school based health centers.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		4.2	15	20	15.5
Annual Indicator	3.1	10.2	15.6	15.3	5.0
Numerator	597	1986	3039	2982	970
Denominator	19439	19439	19439	19439	19439
Data Source				School-Based Health Center database	School-Based Health Center database
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	15.5	16	16	16.5	

Notes - 2009
Source: This CY2009 figure is less then previous years for several reasons. (1) In one of the largest cities - a budget crisis; the transfer of 10 busy school based health center clinics to diferent management; and with services and transition inturruptions resulted in a reduction in the expected number of patients of more then 50%. (2) As a result of the review of the school based health center client database that found patients were included who did not actually attend the actual SBHC schools these individuals were removed from the database with a resulting reduction of the number of patients by more then 40%. (3) The number of patients seen by the SBHCs has essentially plateaued .

Notes - 2008
Source: Baseline denominator is 2003-2004 number of students (19,439) receiving SBHC services.
2007-8 there were 22,421 students seen. These 2,982 additional students seen represent a 15.3% increase over the baseline. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed

as a percentage increase over this original base year. Adjustments were made to the 2009-2013 annual performance objectives due to the most recent data that appears to show plateau of the number of students receiving services at SBHCs.

Notes - 2007
Source: 2006-7 School-Based Health Center database, CT Dept of Public Health, Family Health Section. Baseline denominator for the start of this SPM represents the 2003-2004 number of students (19,439) receiving SBHC services. In School Year 2006-7 there were 22,478 students seen. These 3039 additional students seen represent a 15.6% increase over the base year. Projections for the Annual Performance Indicator are based on an additional increase in the number of students receiving SBHC services each year expressed as a percentage increase over this original base year.

a. Last Year's Accomplishments
The percent increase in the number of students who received services in SBHCS was only 5.0%. This is a dramatic change but is explained by several factors. (1) Due to budget crises in several busy SBHC sites resulted in service and transition interruptions that reduced the expected number of patients by more than 50%; (2) The number of patients was reduced by more than 40% when patients who did not attend the school where the SBHC site actually existed were removed form the data; and (3) The patients that have been seen over time has reached a plateau relative to the physical space, hours and staffing levels.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care.		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers.	X			
3. Provide outreach to targeted populations (i.e. pregnant substances users).		X		
4. Provide support, information and advocacy to pregnant teens.	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers.	X			
6. Promote early enrollment into prenatal care as linkage from programs such as WIC.		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early.		X		
8.				
9.				
10.				

b. Current Activities
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

c. Plan for the Coming Year
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

State Performance Measure 5: *Percent of schools that have used a program to reduce obesity through physical exercise and nutrition education programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		6.5	7	7.5	8
Annual Indicator		6.5	6.5	6.5	6.5
Numerator		19	19	19	19
Denominator		294	294	294	294
Data Source				The School Nutrition and Physical Activity Practic	The School Nutrition and Physical Activity Practic
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.5	9	9.5	10	

Notes - 2009
Source: CY2009 data not available. The School Nutrition and Physical Activity Practices (SNPAP) survey was intended to be the source of data for this measure. However, the State Dept. of Education (SDE) was unable to repeat this survey due to budget constraints and staffing resources.
State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

Notes - 2008
Source: CY2008 data not available. The School Nutrition and Physical Activity Practices (SNPAP) survey was intended to be the source of data for this measure. However, the State Dept. of Education (SDE) was unable to repeat this survey due to budget constraints and staffing resources.
State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

Notes - 2007
Source: CY 2007 data are not available.
State Dept of Education (SDE) completed their first School Nutrition and Physical Activity Practices (SNPAP) survey in the Spring 2006. Therefore, there is no 2005 baseline data. We have projected a conservative 0.5% increase annually among the approximately 1000 public schools in the state that will implement school policies that promote healthy lifestyles to a degree which meets the acceptable level.

a. Last Year's Accomplishments
The SNAP-Ed (Supplemental Nutrition Assistance Program--Education) annual funds continued to focus on their preschool nutrition education program to increase fruit & vegetable consumption among children and their families in SNAP eligible households. It encourages healthy eating in combination with daily physical activity. The program uses the Captain 5 A Day curriculum and teachers implement the curriculum after participating in a train-the-trainer workshop. The program also includes a strong parent component with take-home notes for parents and parent

workshops -- Supermarket Smarts.

Program staff continued to provide technical assistance and manage Preventive Health And Health Services Block Grants with Local Health Departments/Districts that promote physical activity and healthy eating.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support allocation of $500,000 state funds to develop fitness programs and nutrition programs for overweight children.				X
2. Promote partnership with newly created Obesity Program within DPH.				X
3. Promote partnership with state Department of Education.				X
4. Support partnerships with school-based health centers and community health centers.				X
5. Support survey through Department of Education to monitor school policies across the state.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Needs Assessment identified a similar SPM and will continue work on reducing the prevalence of obesity.

c. Plan for the Coming Year
Needs Assessment identified a similar SPM and will continue work on reducing the prevalence of obesity.

State Performance Measure 6: *Percent of infants born to women under 20 years of age receiving prenatal care in the first trimester*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		70.5	70.5	70.7	70.9
Annual Indicator	69.8	69.8	70.9	70.9	73.0
Numerator	1984	2002	2015	2015	2041
Denominator	2842	2867	2841	2841	2797
Data Source				CT DPH Vital Statistics	CT DPH Vital Statistics
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	71.1	71.3	71.4	71.5	

Notes - 2009

Source: CY2009 data are not available.
CTDPH Vital Statistics CY2008 final data.

Notes - 2008
Source: CTDPH Vital Statistics CY2008 final data.

Notes - 2007
Source: CTDPH Vital Statistics CY2007 final data.

a. Last Year's Accomplishments
This measure was met for CY2008. The CY 2008 figure of 73% continued the increasing trend of women under 20 years receive prenatal care in the first trimester (and was higher than the goal of 70.7%).

Epidemiology staff have executed the contract with Pegus Research to conduct Round 3 of the CT PRATS survey. Work has been completed to finalize the sampling plan and prepare for the survey to begin.

Family Planning continued to provide reproductive health care to outreach and refer pregnant women to community-based programs to promote early prenatal care.

The FIMR program to the five original FIMR sites was defunded as of 5/1/09 but has since been re-instated by the State legislature.

The First Time Motherhood/New Parents Initiative Grant was received from HRSA to develop, implement, evaluate, and disseminate novel social marketing approaches that concurrently increase awareness of existing preconception/interconception, prenatal care, and parenting services/programs in Hartford and New Haven and address the relationship between such services and healthy birth outcomes. The grant expanded the social marketing campaign into the Bridgeport area to continue to raise awareness of preconception/interconception, prenatal care, and parenting services and linkages.

The Centering Pregnancy(r) model of group prenatal care was implemented in New Haven at 2 sites. This model provides outpatient prenatal care services to women most at risk for delivering low birth weight infants and works to achieve outcomes that include empowerment and community building, increase satisfaction with care, reduction in preterm births, and increased breastfeeding.

The Case Management for Pregnant Women program continued to provide comprehensive case management to pregnant and/or parenting women to address perinatal health disparities with emphasis on African-American/Blacks, Hispanics, teens, and adolescent fathers.

Healthy Choices for Women and Children, CHCs, and Family Planning continued to provide linkages to prenatal care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide outreach and intensive case management to identify and enroll clients in early prenatal care.		X		
2. Provide culturally and linguistically appropriate services to decrease barriers to prenatal care services and providers.	X			
3. Provide outreach to targeted populations (i.e. pregnant substances users).		X		

4. Provide support, information and advocacy to pregnant teens.	X			
5. Provide pregnancy testing, reproductive health education, counseling and prenatal linkage to community based providers.	X			
6. Promote early enrollment into prenatal care as linkage from programs such as WIC.		X		
7. Provide and promote comprehensive services to encourage women of reproductive age to enter prenatal care early.		X		
8.				
9.				
10.				

b. Current Activities
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

c. Plan for the Coming Year
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

State Performance Measure 7: *Percent of CYSHCN who receive family-centered,community-based, culturally-competent,comprehensive, coordinated family/caregiver support svcs incl. respite in the Regional Medical Home System of Care*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		26.4	54.1	89.8	50.9
Annual Indicator		44.9	86.4		13.7
Numerator			4037	5931	819
Denominator			4675		5963
Data Source				Regional Medical Home Centers	Regional Medical Home Centers
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52.9	53.9	54.4	54.7	

Notes - 2009
Source: Due to changes in contract requirements the CY2008, the numerator would exceed the previously established benchmark, resulting in greater than 100% achievement of this performance measure. For this reason, we changed the wording of this SPM to reflect the percent increase each year of the number of CYSHCN who receive respite and support services compared to the previous year. The number of CYSHCN who receive respite and support services in CY2008 was 5963 and in CY2009 6794 resulting in a percent increase of 13.7%.

Notes - 2008
Source: Due to changes in contract requirements the CY2008, the numerator would exceed the previously established benchmark, resulting in greater than 100% achievement of this performance measure. For this reason, we changed the wording of this SPM to reflect the percent increase each year of the number of CYSHCN who receive respite and support services

using a baseline from CY2007 (the first year that an existing database could provide the total number of CYSHCN served).
CY2008 is based on full year regional site numbers. Annual Performance Objectives for 2008-2013 have been altered to reflect the change in measuring success by 4%, 2%, 1%, .5% and .25% respectively.

Notes - 2007
Source: The numerator is based on a full year of the number CYSHCN served by the regional medical home sites. The denominator is the estimated number of CYSHCN that the regional medical home sites were expected to serve.
The annual performance objectives for 2008-2012 were updated to reflect this more recent data.

a. Last Year's Accomplishments
/2010/ Title of this State Performance Measure has been changed to "Percent Increase in the number of CYSHCN who receive respite and support services each year."//2010//
Due to changes in contract requirements the CY2008, the numerator would exceed the previously established benchmark, resulting in greater than 100% achievement of this performance measure. For this reason, we changed the wording of this SPM to reflect the percent increase each year of the number of CYSHCN who receive respite and support services using a baseline from CY2007 (the first year that an existing database could provide the total number of CYSHCN served).

The measure was met with an increase in the number of CYSHCN who receive respite and support services in CY2009 (6,782 CYSHCN) compared to CY2008 (5,931 CYSHCN). The Connecticut Medical Home Initiative (CMHI) for CYSHCN continued to assure more families of children/youth with special health care needs have access to a family-centered, community-based, culturally-competent, comprehensive, coordinated system of care. CMHI contractors provided family/caregiver support services that covered a full range of needs including medical, educational, and community supports; and linked information through the medical home.

The Connecticut Lifespan Respite Coalition (CLRC), functioning as a component of the CMHI, continued to implement respite protocols, and distribute both respite and department approved extended service funds for Connecticut families. Respite services are family-directed with the provider and location of respite services of the family's choice.

CT Medical Home Initiative for CYSHCN care coordinators continued to support medical homes in providing family-centered, community-based, culturally competent, comprehensive, and coordinated family/caregiver support services including respite to children and youth with special health care needs. Contractors captured data related to care coordination activities covering a full range of needs including medical, educational, and community supports.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide family-centered, community-based, culturallycompetent, comprehensive, and coordinated family/caregiver support services.		X		
2. Capture and document care coordination activities.		X		
3. Distribute “Get Creative About Respite” and “Directions” manuals, and family directed respite funds.	X			
4. Provide forums for sharing of “Get Creative About Respite” manual and other community support solutions.		X		
5. Work with state agencies, community providers, and families to further expand the sharing of community support solutions.				X

6. Follow national Lifespan Respite legislation for possible funding opportunities.				X
7.				
8.				
9.				
10.				

b. Current Activities
Needs Assessment identified a similar SPM and will continue work on addressing the needs of the CYSHCN population.

c. Plan for the Coming Year
Needs Assessment identified a similar SPM and will continue work on addressing the needs of the CYSHCN population.

State Performance Measure 8: *Percent of licensed child care centers serving children age birth to five who have on-site health consultation, as defined by the standards in "Caring for Our Children".*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		0	0	0	0
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	

Notes - 2009
Source: CY2009 data not available for State Performance Measure, as most of the Region 1 states did not have the capacity to provide information to address this issue.

Notes - 2008
Source: CY2008 data not available for State Performance Measure, as most of the Region 1 states did not have the capacity to provide information to address this issue.

Notes - 2007
Source: CY2007 data are not available.

a. Last Year's Accomplishments
/2009/ Title of this SPM has been modified to "The percent of licensed child day care centers serving preschool age children that have reported having contracts with the required four consultants (health, dental, educational and social service) to conduct the required site visits, and to ensure that the health, dental and social service consultants' licenses are current."//2009//

FHS staff did not actively pursue work on this State Performance Measure, as most of the Region 1 states did not have the capacity to provide information to address this issue. This was briefly discussed during the monthly Region 1 conference calls and at the February 2009 AMCHP meeting where states were more inclined to pursue a measure around rural health.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Meet with the Radon Program to review the collected Day Care Licensing inspection forms.				X
2. Enter forms into an Excel spreadsheet with the assistance of the Radon Program.				X
3. Review data looking to identify Child Day Care Centers that were non-compliant on the inspection forms on maintaining a health consultation log.				X
4. Establish baseline on the compliance of maintaining the health consultation log at Child Day Care Centers for future comparison.				X
5. Participate on the monthly Region 1 conference calls to continue the dialogue regarding the progress of other Region 1 states in meeting this measure.				X
6. Discuss progress towards meeting this measure at the CT Early Childhood Partners quarterly steering committee meeting, to seek additional input from steering committee members.				X
7.				
8.				
9.				
10.				

b. Current Activities
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

c. Plan for the Coming Year
This State Performance Measure will be retired this year due to the findings from the five year Needs Assessment.

E. Health Status Indicators

Introduction
Health Status Indicators related to birth outcomes have remained generally unchanged. Recent activities at the state level have placed emphasis on low birth weight and may help address these indicators. Activities include: 1) development of an updated strategic plan developed within the FHS for its activities; 2) a survey of all activities within DPH that relate to low birth weight; 3) testimony at a recent hearing about the effect of the recession on children; and 4) a two-day workshop to address persistent disparities in the state's perinatal system of care.

Recent state laws may help address the suggestive increasing trend in unintentional injuries and deaths within the state. These laws include: 1) a graduated driver's licensing for teens under 18 years old; and 2) a law prohibition on the use of hand-held cell phones while driving.

A striking increase in the rate of Chlamydia cases for teens and young adults needs to be addressed, and DPH will work with the STD program to support its efforts.

All public health interventions within the state need to be culturally-sensitive and linguistically-

sensitive, and be conscious of the micro-culture that exists among the different age groups within the MCH population.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	8.2	8.1	8.0	8.0
Numerator	3312	3389	3357	3226	3226
Denominator	41416	41455	41308	40099	40099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data CY 2008.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Notes - 2007
Source: CTDPH final Vital Statistics data CY2007.

Narrative:
The rate of live births weighing less than 2,500 grams decreased slightly from 2006 to 2009, from a high of 8.2 per 100 live births in 2006 to 8.0 per 100 live births in 2009. The low birth weight rate in 2009 was the same as that observed in 2005, suggesting that recent interventions may have had a small positive effect on birthweight. A strategic plan was recently developed within the FHS to address low birth weight, and several objectives have been implemented, including receipt of federal funding for a federal Healthy Start community in Hartford. We will continue to implement strategies as funds permit.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.9	6.1	5.9	5.9	5.9
Numerator	2334	2434	2336	2243	2243
Denominator	39517	39679	39473	38317	38317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data CY 2008.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Notes - 2007
Source: CTDPH final Vital Statistics data CY2007.

Narrative:
After an initial increase in the rate of singleton low birth weight from 2005 to 2006, the rate dropped to 2005 levels in 2007 and has remained at 5.0 per 100 live births. Several home visiting programs were recently implemented, such as Care Management for Pregnant Women, and Healthy Choices for Women and Children. Funding for these programs will continue as funds permit. Additional home visiting programs made possible by the ACA of 2010 may also impact this measure.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.6	1.7	1.5	1.6	1.6
Numerator	666	686	637	623	623
Denominator	41415	41455	41308	40099	40099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data CY 2008.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Notes - 2007
Source: CTDPH final Vital Stastica data for CY2007.

Narrative:
The very low birth weight rate fluctuated from 2005 to 2009, ranging from a low of 1.5 per 100 live births to a high of 1.7 per 100 live births. Home visiting and other prenatal services described previously may help impact this measure in the future. In addition, a focus on preconception screening and care, as described in the FHS low birth weight plan, may positively affect this measure.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.2	1.3	1.1	1.1	1.1
Numerator	474	499	431	410	410
Denominator	39517	39679	39473	38317	38317
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data CY 2008.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Notes - 2007
Source: CTDPH final Vital Statistics data CY2007.

Narrative:
The singleton very low birth weight rate has fluctuated slightly since 2005, but generally has remained steady since 2007, at 1.1 per 100 live births. A recently implemented media campaign on preconception health was implemented in New Haven and Hartford through the First Time Motherhood initiative. The media campaign was focused on the African American community and may positively impact this measure in the future.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.0	2.7	3.7	3.3	3.3
Numerator	27	18	25	22	22
Denominator	682998	655901	669187	662713	665272
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data for 2008 were repeated in 2009 pending more current data. A rolling average was used. The

numerator is the average of 2007, 2008 and 2009 original numbers (25, 22, 22 provisional). The denominator is the average of 2007,2008 and 2009 original number (668663, 663576, 663576).

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008. A rolling average was used. The numerator is the average of 2006, 2007, 2008 original numbers (18, 25, 22). The denominator is the average of 2006,2007 and 2008 original number (665901, 668663, 663576).

Notes - 2007
Source: CTDPH final Vital Statistics data for CY 2007. A rolling average was used. The numerator is the average of 2005, 2006, 2007 original numbers (27, 18, 25). The denominator is the average of 2005, 2006 and 2007 original numbers (682998, 655901, 668663).

Narrative:
The death rate per 100,000 due to unintentional injuries among children aged 14 year and younger has fluctuated since 2005, from a low of 2.7 per 100,000 in 2006, to a high of 4.0 per 100,000 in 2005. MCH staff will work with injury prevention staff in the coming year to better understand why types of injuries are most prevalent in the state and to seek interventions that may impact this measure.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.5	0.8	1.2	1.1	1.1
Numerator	10	5	8	7	7
Denominator	682998	665901	672521	666047	665272
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. Data for 2008 were repeated in 2009, pending more surrent data. A rolling average was used. The numerator is the average of 2007, 2008, 2009 original numbers (10, 6, 6 provisional). The denominator is the average of 2007,2008 and 2009 original number (668663, 663576, 663576).

Notes - 2008
Source: CT DPH Vital Statistics final CY2008 with denominator from 2008 DPH population estimates. A rolling average was used. The numerator is the average of 2006, 2007, 2008 original numbers (5, 10, 6). The denominator is the average of 2006, 2007 and 2008 original number (665901, 668663, 663576).

Notes - 2007
Source: CT DPH Vital Stats final CY2007 with denominator from 2007 DPH population estimates. A rolling average was used. The numerator is the average of 2005, 2006, 2007 original numbers (10, 5, 10). The denominator is the average of 2005, 2006 and 2007 original numbers (682998, 655901, 668663).

Narrative:
The death rate among children 14 years and younger due to motor vehicle accidents fluctuated from 2005 to 2009, from a low of 0.8 per 100,000 in 2006 to a high of 1.5 per 100,000 in 2005 and 2007. No trend is apparent.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	16.0	20.8	15.8	14.1	14.1
Numerator	75	98	75	67	67
Denominator	467721	472149	474211	473747	473747
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 Vital Statistics data are not available. CT DPH final Vital Statistics data CY 2008 with denominator from 2008 population estimates.

Notes - 2008
Source: CT DPH final Vital Statistics data CY2008.

Notes - 2007
Source: CTDPH final Vital Statistics data CY2007.

Narrative:
The death rate per 100,000 for unintentional injuries among youth age 15 -- 24 years old due to motor vehicle crashes decreased since 2006 to a low of 14.1 in 2008 and 2009. New teen driving laws were implemented across the state in 2009, which may positively affect this measure.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	220.4	235.9	228.8	231.6	231.6
Numerator	1505	1571	1530	1537	1537
Denominator	682998	665901	668663	663576	663576
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 hospitalization data not available. Hospitalization data for 2008 was used.

Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2008
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2007
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm as of September 5, 2008.

Narrative:
The rate per 100,000 of all nonfatal injuries among children 14 year old and younger due to motor vehicle accidents fluctuated from a high of 235.9 per 100,000 in 2006 to a low of 220.4 per 100,000 in 2005. The rate was also reduced in 2007, 2008, and 2009.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	22.4	18.3	18.8	17.3	17.3
Numerator	153	122	126	115	115
Denominator	682998	665901	668663	663576	663576
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Source: CY 2009 hospitalization data not available. Hospitalization data for 2008 was used.

Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2008
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2007
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm as of September 5, 2008.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle accidents among youth aged 15 -- 24 years old fluctuated in 2005 and 2006, but has remained constant from 2007 through 2009 at 18.8 per 100,000. New teen driving laws, as well as a new law prohibiting hand-held phones, may positively affect this measure.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	136.8	123.7	148.7	123.7	123.7
Numerator	640	584	705	586	586
Denominator	467721	472149	474211	473747	473747
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Source: CY 2009 hospitalization data not available. Hospitalization data for 2008 was used.

Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2008
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2008, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2008). Prepared under a collaborative arrangement with the U.S. Census Bureau; released May 14, 2009. Available from: http://www.cdc.gov/nchs/nvss/bridge_race.htm as of September 2, 2009.

Notes - 2007
Source: Hospital Discharge data: CT Hospital Association

Population data: National Center for Health Statistics. Postcensal estimates of the resident population of the United States for July 1, 2000-July 1, 2007, by year, county, age, bridged race, Hispanic origin, and sex (Vintage 2007). Prepared under a collaborative arrangement with the U.S. Census Bureau; released August 7, 2008. Available from: http://www.cdc.gov/nchs/about/major/dvs/popbridge/popbridge.htm as of September 5, 2008.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth 15-24 years old increased from a low of 123.7 per 100,000 in 2006 to a high of 148.7 per 100,000 in 2007, 2008, and 2009. New teen driving laws in the state may positively affect this measure in the future.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	29.0	25.0	31.6	32.5	32.5
Numerator	3060	3025	3328	3426	3427
Denominator	105336	120767	105335	105335	105335
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: 2009 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2008

Source: 2008 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Notes - 2007
Source: 2007 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Narrative:
The rate per 1,000 women aged 15-19 years old with a reported case of Chlamydia has generally increased from a low of 25.0 per 1,000 in 2006 to a high of 32.5 per 1,000 in 2008 and 2009. This ominous increase in the rate of this sexually-transmitted disease needs to be addressed. Recent efforts by the STD program will be supported and may have a positive impact on this measure.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	8.3	8.1	8.9	8.9
Numerator	4954	4886	4996	5511	5487
Denominator	617215	589349	617215	617215	617215
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Source: 2009 CT DPH STD MIS, CT STD Control Program. Denominator from 2000 Census.

Notes - 2008
Source: 2008 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Notes - 2007
Source: 2007 CT DPH STD MIS, CT STD Control Program
denominator = 2000 Census.

Narrative:
Similar to HIS #05A, the rate per 1,000 women aged 20-24 years old with a reported case of Chlamydia has fluctuated since 2005, but has shown a general increase to a high of 8.9 per 1,000 in 2008 and 2009. Interventions are needed to stem the increase in this STD among this age group.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	42446	32357	6289	243	1894	56	1607	0
Children 1 through 4	169191	132344	21772	1074	7608	179	6214	0
Children 5 through 9	218859	174734	26825	1195	8746	261	7098	0
Children 10 through 14	233080	188299	29411	947	8174	241	6008	0
Children 15 through 19	250053	203099	33282	1090	7081	253	5248	0
Children 20 through 24	223694	181093	29795	1055	7127	265	4359	0
Children 0 through 24	1137323	911926	147374	5604	40630	1255	30534	0

Notes - 2011
Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Narrative:
Among all children 0-24 years old in Connecticut, 13.0% were Black/African American, 0.5% were American Indian, 3.6% were Asian, and 2.7% were of multiple races. A large majority (80%) were of White/Caucasian race. The concentration percentage of Black/African American children was among infants (14.8% of all races), compared to a range of 12.3% to 13.3% among other age groups. The highest percent of Native Hawaiians and multiple races were also infants (0.13% and 3.8%, respectively). The highest percentage of Asians and American Indian children was among the 1-4 year old age group. In sharp contrast, the highest percentage of White/Caucasian children was among teens aged 15-19 years. This indicates a shift in the state's childhood population toward minority races, and emphasizes the need for culturally-sensitive public health interventions.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	32801	9645	0
Children 1 through 4	134601	34590	0

Children 5 through 9	180470	38389	0
Children 10 through 14	197291	35789	0
Children 15 through 19	213869	36184	0
Children 20 through 24	190569	33125	0
Children 0 through 24	949601	187722	0

Notes - 2011
Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Source: CT DPH, 2008 Population Estimates, Backus & Muller O.H.C.Q.S.A.R.

Narrative:
Of all children aged 0-24 years in Connecticut, the percent of Hispanic/Latino children was 15.7%. Compared to this overall percentage among all ages, the percent of Hispanic/Latino infants was 20.2%. No other age category had such a high concentration of Hispanic/Latino children. This indicates that the demographics of the childhood population is shifting toward more ethnic minorities, and culturally-sensitive and linguistically-sensitive public health interventions are needed.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	26	13	10	0	0	1	0	2
Women 15 through 17	846	619	204	3	0	2	0	18
Women 18 through 19	1945	1336	518	6	2	10	0	73
Women 20 through 34	28842	22186	3980	194	254	1488	0	740
Women 35 or older	8726	7163	766	17	155	379	0	246
Women of all ages	40385	31317	5478	220	411	1880	0	1079

Notes - 2011
Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Narrative:
Among all births in the state, 78% were to White/Caucasian women and 13.6% were to Black/African American mothers. Among White/Caucasian mothers, the highest concentration of births was to women 35 years of age and older (82.1%). Among Black/African American mothers, the highest concentration of births was among those less than 15 years of age (38.5%). Most American Indian and Native Hawaiian mothers were 20-34 years old, and most Asian mothers were at least 35 years of age. These data indicate that culturally-sensitive messages also need age-appropriate, in which messages to Black/African American mothers should be directed at younger ages, while messages to other race groups should be addressed to older age groups.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	15	11	0
Women 15 through 17	368	476	2
Women 18 through 19	1061	876	8
Women 20 through 34	22254	6348	240
Women 35 or older	7607	934	185
Women of all ages	31305	8645	435

Notes - 2011
Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Source: CT DPH, 2008 final Vital Statistics.

Narrative:
Among all births in the state, 21.6% were to women of Hispanic/Latino ethnicity. Compared to this overall percentage among all ages, the percent of Hispanic/Latino births to teens 15-17 years of age was 56.5%, an increase of 34.8%. No other age category had such a high percentage of Hispanic/Latino mothers. These data indicate that culturally-sensitive messages to Hispanic/Latino mothers need to include messages to teens.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	240	125	67	0	3	15	7	23
Children 1 through 4	33	22	5	0	1	0	1	4
Children 5 through 9	16	7	7	0	0	0	0	2
Children 10 through 14	22	13	7	0	0	0	1	1
Children 15 through 19	97	59	26	1	0	1	0	10
Children 20 through 24	195	125	37	0	1	0	7	25
Children 0 through 24	603	351	149	1	5	16	16	65

Notes - 2011
Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Narrative:
Among deaths to children ages 0-24 years in Connecticut, 58.2% are to White/Caucasian children, while 24.7% are to Black/African American children. A smaller percentage of childhood deaths occurred to Hawaiian and multi-race groups (2.6%) and the Asian race group (0.8%). The highest concentration of deaths to White/Caucasian and Asian children occurred to those 1-4 years of age. The highest concentration of deaths to Hawaiian race group was among infants, and the highest concentration of deaths to the Indian race group was among teens aged 15-19 years of age. The highest percent of deaths to children of multiple races was among adolescents aged 10-14 years of age. These data suggest that the causes of death to various race groups vary among race groups, and that culturally-sensitive interventions are needed.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	178	58	4
Children 1 through 4	25	8	0
Children 5 through 9	15	1	0
Children 10 through 14	17	5	0
Children 15 through 19	85	11	1
Children 20 through 24	155	37	3
Children 0 through 24	475	120	8

Notes - 2011
Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Source: CT DPH 2008 Provisional Vital Statistics.

Narrative:
Among deaths to children 0-24 years old in Connecticut, 20.2% were to Hispanic/Latino children. The highest percentage of deaths to Hispanic/Latino children were generally distributed across all age groups, but were more pronounced among infants and children through age 4 years (24.3%), and among adolescents aged 10-14 years (22.7%).

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	913629	730833	117579	4549	33503	990	26175	0	2008
Percent in household headed by single parent	7.2	5.2	18.9	0.0	4.4	0.0	19.7	22.8	2008
Percent in TANF (Grant) families	0.0	68.5	29.2	0.6	1.2	0.3	0.3	0.0	2009
Number enrolled in Medicaid	245148	183976	51924	1264	7476	266	242	0	2009

Number enrolled in SCHIP	15460	10768	1800	25	635	23	236	1973	2009
Number living in foster home care	5422	2716	1760	4	27	3	386	526	2009
Number enrolled in food stamp program	117414	83374	31281	647	1849	152	111	0	2009
Number enrolled in WIC	46755	30854	11249	2171	944	652	884	1	2009
Rate (per 100,000) of juvenile crime arrests	3935.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	1.7	1.0	2.9	2.8	0.9	0.0	0.0	0.0	2007

Notes - 2011
Source: CT DPH Vital Statistics 2008 Population Estimates; Backus & Mueller.

Source: U.S. Bureau of the Census, American Community Survey 2008, Table #S0201. Data represents female head of household with own children under age 18 as the percent of all households. Race and ethnicity for the combined heads of household are not available from this source.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT DPH CY2009, WIC Program, Susan Hewes.

Source: Ct Dept. of Public Safety; Crimes Analysis Unit CY:2007 juvenille arrests per 0-19 population. Total number of arrests were only available. Breakdown by race was not available.

Source: CT Dept. of Education, 2006-2007 Statewide annual dropout rate.

Source: CT Dept. of Children and Families, FFY 2009. Numbers include children placed due to abuse/neglect as well as those placed for other resons including delinquency matters, voluntary services program, probate court and Interstate Compact.

Narrative:
Among children 0-19 years old, 7.3% were living in single households. Of all children living in single households, 22.7% were Black/African American and 5.2% were White/Caucasian. Among children living in TANF families, 67.2% were White/Caucasian, while 30.6% were Black/African American. The percent of high school dropouts in the state was 1.8%. Among high school dropouts, 2.6% were Black/African American, 2.2% were Native Indian, and 1.2% were

White/Caucasian. These data indicate the children living in high risk households in the state are more likely to be of minority race, and emphasize the need for culturally-sensitive interventions.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	759032	154597	0	2008
Percent in household headed by single parent	5.9	20.0	0.0	2008
Percent in TANF (Grant) families	58.6	41.4	0.0	2009
Number enrolled in Medicaid	166082	79065	0	2009
Number enrolled in SCHIP	11863	3441	156	2009
Number living in foster home care	4083	1339	0	2009
Number enrolled in food stamp program	74450	42963	0	2009
Number enrolled in WIC	23679	23074	1	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	4.4	0.0	2007

Notes - 2011
Source: CT DPH Vital Statistics 2008 Population Estimates; Backus & Mueller.

Source: U.S. Bureau of the Census, American Community Survey 2008, Table #S0201. Data represents female head of household with own children under age 18 as the percent of all households. Race and ethnicity for the combined heads of household are not available from this source.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT Dept. of Social Services, FFY 2009.

Source: CT DPH CY2009, WIC Program, Susan Hewes.

Source: Ct Dept. of Public Safety; Crimes Analysis Unit CY:2007 juvenille arrests per 0-19 population breakdown by ethnicity was not available.

Source: CT Dept. of Education, 2006-2007 Statewide annual dropout rate.

Source: CT Dept. of Children and Families, FFY 2009. Numbers include children placed due to abuse/neglect as well as those placed for other resons including delinquency matters, voluntary services program, probate court and Interstate Compact.

Narrative:
Among children 0-19 years old who were living in a single household, 20.0% were Hispanic/Latino. Among Hispanic/Latino children, 41.4% were living in TANF families and 4.4% were high school dropouts.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	843338
Living in urban areas	797575
Living in rural areas	121472
Living in frontier areas	0
Total - all children 0 through 19	919047

Notes - 2011
Source: CT 2008 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2008 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2008 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Source: CT 2008 data from American Community Survey; (http://factfinder.census.gov); From Table B01001 SEX BY AGE. Using geo components from the options drop down and then selecting Urban, Rural, In Metropolitain Statistical Area. Table results were posted into Excel to obtain subtotals for the 0-19 yesr olds. (It appears the american Community Survey was not the data source used in the FFY 2009 MCHBG Application).

Narrative:
Of all children in Connecticut ages 0-19 years, 91.8% lived in metropolitan areas of the state, and 86.8% lived in urban areas. Only 13.2% lived in rural areas. These data indicate that public health interventions implemented in urban areas of the state are more likely to reach the largest proportion of the childhood population.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total

Total Population	3390665.0
Percent Below: 50% of poverty	4.1
100% of poverty	9.3
200% of poverty	20.7

Notes - 2011
Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1701.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1701.

Narrative:
Across the state of Connecticut, 4.1% of its population was living below 50% of the federal poverty level, 9.3% were living below the 100% federal poverty level, and 20.7% were living below the 200% federal poverty level.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	799298.0
Percent Below: 50% of poverty	5.5
100% of poverty	12.5
200% of poverty	20.7

Notes - 2011
Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1703.

Source: U.S. Bureau of Census 2008 American Community Survey, Table #S1701.

Narrative:
Across the state of Connecticut, 5.5% of its children were living below the 50% federal poverty level, 12.5% were living below the 100% federal poverty level, and 20.7% were living below the 200% federal poverty level. Compared to HIS #11, these data suggest that children in the state are more likely to live in poverty and at risk for poor short-term outcomes than adults.

F. Other Program Activities

Many other programs within DPH affect the MCH population but are not funded through MCHBG. Some of these are listed below:

The Asthma Program's mission is to reduce asthma-associated morbidity and mortality and improve the quality of life for people with asthma. The Asthma Program and FHS have collaborated to assess Title V program data available to evaluate appropriate asthma diagnosis and medical management and patient self-management education for children diagnosed with asthma.

The Connecticut Breast and Cervical Cancer Early Detection Program provides screening, diagnostic, and treatment referral services through 14 major health care facilities and over 350 clinical subcontractors throughout the state. The Program also provides, case management, patient and public education and outreach targeting uninsured and underinsured Connecticut women, as well as professional education and quality assurance.

The Childhood Lead Poisoning Prevention and Control Program (CLPPCP) operates a comprehensive lead surveillance system, provides professional and community education services and operates 2 regional lead treatment centers. The DPH laboratory provides blood lead testing. CLPPCP also provides regulatory oversight and consultative services, and funding support for two Regional Lead Treatment Centers. The program's major goal is to eliminate elevated blood lead levels (>10mcg/dL) in children less than 6 years of age in CT by 2010.

Chlamydia Infertility Prevention provides free chlamydia screening and treatment services to females and their partners who attend targeted Planned Parenthood clinics. Free services are available at clinics to uninsured sexually active females 25 years of age and younger and their sexual partners.

Comprehensive STD Prevention Systems Projects provides services to reduce the transmission and incidence of STDs including surveillance to monitor the trends facilitating individual case intervention.

Enhanced Perinatal HIV Surveillance receives CDC funding to conduct surveillance. All perinatal HIV exposures (approximately 75 infants per year) are followed-up with medical record reviews to collect information about maternal HIV testing, prenatal care, risk factors, treatment compliance, etc.

"Five-a-Day" Head Start Project focuses on providing direct nutrition education to Food Stamp eligible families in CT with the "Captain 5-A-Day" program for children and the "Supermarket Smarts" program for parents and families. These programs are delivered through workshops by state nutrition staff and provide education on food budgeting and developmentally appropriate feeding practices, and encourage dietary behavior modification including the purchase and consumption of fruits, vegetables and other low-fat foods.

DPH worked the Governor's Collaboration for Young Children to establish the Healthy Child Care CT (HCC-CT) initiative. Its goal is to achieve optimal health and development for all children in childcare by guiding and supporting service integration between the childcare community and health care providers. DPH participates on the HCC-CT leadership team, which has established a regional Core Committee representing organizations that play a key role in the planning and delivery of childcare and health care for children and their families. HCC-CT also works closely with the national Healthy Child Care America campaign, which is coordinated by the AAP with support from the DHHS Child Care and MCH Bureaus.

The Connecticut Immunization Program activities are designed to prevent disease, disability and death from vaccine-preventable diseases in infants, children, adolescents and adults through surveillance, case investigation and control, vaccination, monitoring of immunization levels, provision of vaccine and professional and public education. The Immunization Action Program funds seven full time health departments, two health districts, one VNA and one regional community provider to conduct activities to raise immunization rates and the Vaccines for

Children program provides free vaccines to over 600 health care providers to eliminate cost as a barrier to receiving immunizations. Also, The CT Immunization Registry and Tracking System (CIRTS) permanently records and tracks all CT children's immunizations given in early childhood.

Perinatal Hepatitis B Prevention: All hepatitis B positive pregnant women and their providers are contacted to provide education about the implications of hepatitis B infection in pregnancy, offer testing and vaccination to family members and ensure that the infant receives appropriate immunization and testing.

Ryan White Care Act provides federal support for comprehensive health and social services for people living with AIDS and HIV disease, including women, infants and children. There are many AIDS activities aimed to serve women, infants, and adolescents.

Sexual Assault Prevention and Intervention Services provides direct services to victims of rape and other sexual assaults throughout the state as well as primary prevention education. DPH contracts with the CT Sexual Assault Crisis Services, Inc., an umbrella agency, to coordinate these efforts. A Sexual Violence Prevention Planning Committee was convened with key community stakeholders to develop a Sexual Violence Prevention Plan. Implementation of this plan will occur over the next several years.

WIC serves approximately 60,000 participants in CT through 12 agencies located throughout the State. The WIC Program provides food, nutrition, breastfeeding and health education, and referral services for categorically eligible individuals found to be at nutritional and/or medical risk. Categorically eligible individuals are defined as pregnant, breastfeeding and postpartum women, and infants and children up to age five who reside in CT.

The CT State WIC Office collaborated with the Supplemental Nutrition Assistance Program (SNAP-Ed) Program in a joint initiative involving the SNAP-Ed Program providing "Loving Your Family, Feeding Their Future" group education classes at local WIC agencies.

WISEWOMAN (The Well-Integrated Screening and Evaluation for Women Across the Nation Program) provides cardiovascular disease risk reduction screening and lifestyle modification intervention services to uninsured and underinsured Connecticut women at eight major contracted health care provider sites throughout the state.

G. Technical Assistance

During the FFY 2009, CT was fortunate to receive technical assistance in the following area:

1. Children and Youth with Special Health Care Needs
The MCHB National Center for Cultural Competency (NCCC) completed a technical assistance visit that addressed cultural competence for the children and youth with special health care needs and the MCH programs. The NCCC consultants worked directly with DPH program staff through a daylong workshop to help develop strategies to incorporate cultural competency into community based programs. The consultants also held an additional day long forum addressing cultural competency issues with the CT Medical Home Initiative for CYSHCN and other stakeholders including: members of the DPH Medical Home Advisory Council, health care providers, CBO staff, and agency staff from DSS, DCF, and SDE. This TA was intended to increase the skill levels of both contract grantees and DPH staff in developing strategies for successful incorporation of cultural competence through the CYSHCN and MCH programs. The NCCC is committed to working closely with Connecticut over the next year.

2. Pregnant women, mothers and Infants
The CT and MA DPHs received technical assistance in the area of infrastructure building. A contractor, Entertaining Diversity, worked with staff from both state health departments to

enhance their skills in developing focus group surveys and conducting focus groups. African American women of reproductive age were surveyed (in CT and MA) regarding influenza prevention messaging. In CT, the information gained from the focus groups was translated into a culturally appropriate influenza prevention campaign (small newspaper print and transit bus ads) and will be evaluated using our point-in-time survey PRATS and MA's PRAMS. CDC funds were leveraged for the dissemination of the ad. State staff utilized the skills gained and conducted post campaign focus groups that confirmed the message resonated with the target group. This process was shared with the CT DPH's executive leadership team, related to future messaging of health issues and the need to seek input from the community prior to developing messages (and not just translating existing messages). The process and the final ad was published on the Robert Wood Johnson (Sharing Nurses' Knowledge E-Journal) website, as well as in the AMCHP newsletter.

Technical Assistance requests for the next year will focus on:

1. CYSHCN
The DPH- contracted community based medical homes have a varying degree of expertise in the utilization of data systems. We will focus on the ability to improve care coordination capacity by better understanding and utilizing the National Data Resource Center information. The medical homes have formed a learning collaborative. The purpose of this collaborative is to address an identified challenge of coordination with sub-specialists. The TA will be used to provide consultation to the collaborative to strengthen the medical home care coordination system.

2. Pregnant Women
The DPH is currently working with a consultant to address the perinatal system of care in the state. TA for next year is requested to take the information obtained from the state level process and replicate it at the local level. The anticipated outcome will be a high quality perinatal system of care in urban areas that focus on the reduction of health disparities. Research by the FHS Epidemiologist, Dr. Carol Stone, confirmed an association with a reduced risk for low birth weight outcome with women who are co-enrolled in the WIC program. The requested TA will be used to collaborate with the Ethel Donaghue Translating Research Into Practice (TRIPP) Center at the University of Connecticut, to conduct focus groups to address why women are not co-enrolled. The final TA request is to characterize the demographics of women who smoke in successive pregnancies with the ultimate goal of informing public health intervention strategies. This TA will be used to form a stronger collaboration with the DPH's Tobacco Cessation program.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	4729890	4581699	4729890		4748137	
2. Unobligated Balance *(Line2, Form 2)*	533846	533846	450581		166438	
3. State Funds *(Line3, Form 2)*	7100000	7040000	7100000		7095000	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	12363736	12155545	12280471		12009575	
8. Other Federal Funds *(Line10, Form 2)*	1494321	1494321	6778683		2284695	
9. Total *(Line11, Form 2)*	13858057	13649866	19059154		14294270	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	724160	746143	988779		772130	
b. Infants < 1 year old	1242291	1257931	1316142		1230464	
c. Children 1 to 22 years old	6022249	5936766	5854736		5810242	
d. Children with	4158214	4013701	3825901		3917316	

Special Healthcare Needs						
e. Others	28048	26631	58628		45827	
f. Administration	188774	174373	236285		233596	
g. SUBTOTAL	12363736	12155545	12280471		12009575	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		750000		750000	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	602630		595977		582991	
j. Education	0		0		0	
k. Other						
CYSHCN Integration	0		299506		300000	
ECP	140000		105000		132000	
EHDI	149999		149988		299874	
PCO	119830		119830		119830	
FirstTime Motherhood	0		500000		0	
Immunizations	0		4158382		0	
CYSHCN Integ.	296862		0		0	
Partnership	85000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	4488240	4449794	4503220		4487936	
II. Enabling Services	2208077	2221267	2211755		2230771	
III. Population-Based Services	688156	644202	821126		952809	
IV. Infrastructure Building Services	4979263	4840282	4744370		4338059	
V. Federal-State Title V Block Grant Partnership Total	12363736	12155545	12280471		12009575	

A. Expenditures

There were many overall factors that impacted the actual expenditures in comparison to the FFY2009 budget. Details specific to any significant expenditure variations on each of the Budget Forms are described below.

Form 3

For FFY2009, not all of the Federal Allocation was spent for several reasons, including staff moving to other positions, delays in filling other Title V funded vacancies, and delays in the initiation of certain contracts services.

The decrease in the State Funds in FFY2009 is due to the Genetics Diseases Program receiving $60,000 less in State Match funds than originally projected.

In FFY09, there were no significant expenditure variations from the budgeted amounts (Forms 3, 4, and 5).

B. Budget

State matching funds are met through funding of School-Based Health Centers, The Genetics Diseases Program, and the CYSHCN (Medical Homes). These matching funds will total $3,970,000 for FFY2011. For FFY2009, the maintenance of effort requirement is met from several sources: Community Health Centers, Family Planning Programs and the School-Based Health Centers located throughout the state. The State of Connecticut dollars for these programs total $3,125,000 for FFY2009. The Maintenance of Effort amount for FFY2009 is $7,040,000 (maintenance of effort total includes the matching).

Other state-funded programs that serve the maternal and child health population include: Community Health Centers, Lead Poisoning Prevention, Asthma, Genetic Sickle Cell Program, Healthy Choices for Women and Children, Expanded School Health Services, Rape Crisis and Prevention Services, Youth Risk Behavior Surveillance, and Family Planning. In addition to these programs, there are several state-funded DPH personnel who provide support to the maternal and child health programs.

The requirement that there be three dollars of State matching funds for each four dollars in federal funding is met for FFY2011. The federal allocation for FFY2011 is $4,748,137, which means that the State of Connecticut must match with at least $3,561,103. Maintenance of Effort for FFY2011 is in the amount of $7,095,000, which is $317,809 more than the required FFY1989 base of $6,777,191.

Other federal grants received by the Family Health Section that serve the maternal and child population will include: Healthy Start, Primary Care Office, Rape Prevention and Education, Universal Newborn Hearing Screening, State Systems Development Initiative (SSDI), CYSHCN Integration, and ECP, CT's CECCS program.

The allocation plan requires that 30% of the FFY allocation be budgeted for Prevention and Primary Care services, as well as 30% for Children with Special Health Care Needs. For the FFY2011 award amount, $1,446,098 (30.46%) is allocated for Preventive and Primary Care for Children; and $2,018,915 (42.52%) for the CSHCN program. There is an allocation of administrative costs of $233,596 (4.92%) of the projected federal allocation to all programs.

In FFY2011, the federal allocation is $4,748,137 plus using $166,438 of the carry forward from FFY2009 funds for a total of $4,914,575 of federal funding. When combined with the state funds of $7,095,000 there is a federal-state block grant partnership total of $12,009,575.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.